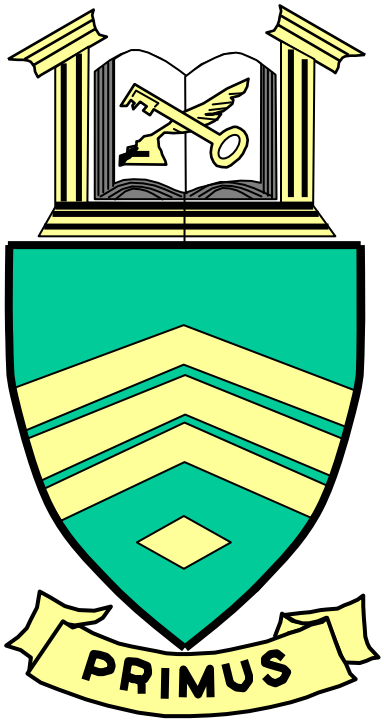
U.S. ARMY SERGEANTS MAJOR ACADEMY (FSC-TATS)

W664 (052002) JUL 02

CASUALTY EVACUATION

PRERESIDENT TRAINING SUPPORT PACKAGE



Overview

Throughout history, armies have had tremendous problems in determining how to evacuate injured soldiers from the battlefield. In planning offensive and defensive maneuvers, one of the most serious concerns facing any leader is how to evacuate casualties. In addition to the occupational hazards, soldiers are subject to hundreds of diseases and nonbattle injuries (DNBI). Correct addressing of these tasks requires that you first understand how the system works. You can dramatically reduce your unit's combat power if you do not plan your resources correctly. This lesson will provide you with a better understanding of casualty evacuation procedures and how to develop a company casualty evacuation plan to fit the needs of your particular unit. Remember that prior casualty evacuation planning for your soldiers is essential and critical in maintaining the welfare of your soldiers and your unit's fighting strength. Keep in mind that the dynamics of our global responsibilities require a casualty evacuation system that is flexible to support the diversity of operations.

Inventory of Lesson Materials

Before starting this lesson ensure you received all materials (pages) required for this Training Support Package. Go to the "**This [TSP or Appendix] Contains**" section on page two of the TSP and the first page of each Appendix, and verify you have all the pages. If you are missing any material, contact the First Sergeant Course Class Coordinator at the training institution where you will attend phase II FSC-TATS.

Point of Contact

If you have any questions regarding this lesson, contact the First Sergeant Course Class Coordinator at the training institution where you will attend phase II FSC-TATS.

PRERESIDENT TRAINING SUPPORT PACKAGE

TSP Number/ Title	W664 Casualty Evacuation
Effective date	JUL 02
Supersedes TSPs	W664, Casualty Evacuation Jun 01
TSP User	This TSP contains a training requirement that you must complete before attending phase II, FSC-TATS. It will take you about two hours to complete this requirement.
Proponent	The proponent for this document is the U.S. Army Sergeants Major Academy. POC: FSC TATS Course Chief, DSN: 978-8854/8848; commercial: (915) 568-8854/8848.
Comments/ Recommend-ations	Send comments and recommendations on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to: COMDT USASMA ATTN ATSS DCF FSC TATS BLDG 11291 BIGGS FLD FT BLISS TX 79918-8002
Foreign Disclosure Restrictions	The lesson developer in coordination with the USASMA foreign disclosure authority has reviewed this lesson. This lesson is releasable to foreign military students from all requesting foreign countries without restrictions.

This TSP Contains

SECTION I ADMINISTRATIVE DATA

Tasks trained This lesson trains the tasks listed in the following table:

Task Number:	400-008-6501
Task title:	Manage casualty treatment and evacuation.
Conditions:	As a first sergeant given student handouts 1, 2, and 3.
Standard:	IAW FM 1-113, FM 7-10, FM 7-12, FM 8-10-6, and CALL Information Paper.
Task Proponent:	U.S. Army Sergeants Major Academy.

Task(s) Reinforced None

Prerequisite Lesson(s) None

Clearance and Access There are no clearance or access requirements for this lesson.

Copyright Statement

No copyrighted material reproduced for use in this lesson.

Reference

The following table lists the reference for this lesson:

Number	Title	Date	Chap	Additional Information
FM 1-113	Utility and Cargo Helicopter Operations	Sep 1997	Chap 6	SH-1
FM 7-10	The Infantry Rifle Company	Dec1990 W/C1, Oct 2000	Chap 8	SH-2
FM 8-10-6	Medical Evacuation in a Theater of Operations Tactics, Techniques, and Procedures	Apr 2000	Chap 7	SH-3
FM 12-6	Personnel Doctrine	Sep 1994	Chap 3	SH-1
CALL Newsletter 97-14	Company Casualty Evacuation			SH-2

Equipment Required

None

Materials Required

This preresident training package contains all material necessary to complete this lesson.

Safety Requirements

None

Risk Assessment Level

Low

Environmental Considerations

None

Lesson Approval The following individuals have reviewed and approved this lesson for publication and incorporation into the First Sergeant Course--The Army Training System.

Name/Signature	Rank	Title	Date
Benjamin M. Salcido	GS09	Training Developer	
Chris L. Adams	SGM	Chief Instructor, FSC	
John W. Mayo	SGM	Course Chief, FSC-TATS	

SECTION II INTRODUCTION

Terminal Learning Objective

At the completion of this lesson, you will--

Action:	Identify the procedures associated with the planning of casualty evacuation at company level.
Conditions:	As a first sergeant in a classroom environment, given extracts of SH-1, SH-2 and SH-3.
Standard:	Identified the procedures associated with the planning of casualty evacuation at company level IAW FM 1-113, FM 7-10, FM 12-6, FM 8-10-4, and Call Newsletter 97-14.

Evaluation

Before entering phase II FSC-TATS, you will receive the end of Phase I Performance Examination that will include questions based on material in this lesson. On that examination, you must answer at least 70 percent of the questions correctly to achieve a GO.

Instructional Lead-in

Timely evacuation of the soldiers from the battle area is essential to their welfare and your unit's fighting strength. This instruction builds on the casualty evacuation tasks taught at BNCOC and ANCOC. As a First Sergeant, you must be certain that all soldiers know the correct procedures for the evacuation of casualties on the battlefield.

SECTION III PRESENTATION

ELO 1

Action:	Identify casualty evacuation operations and management procedures.
Conditions:	As a first sergeant in a classroom environment, given SH-1.
Standard:	Identified casualty evacuation operations and management procedures IAW FM 1-113 and FM 12-6 (SH-1).

Learning Step/ Activity (LS/A) 1, ELO 1

To complete the learning activity, you must--

- Read ELO 1 above.
- Read Student Handout 1.
- Complete questions 1 thru 15.
- Compare your responses with the suggested solution found in the solution/discussion to LE-1 (Appendix B).
- If your response does not agree with the answer in the solution/discussion, review the lesson material.

ELO 2

Action:	Describe a unit's casualty evacuation process.
Conditions:	As a first sergeant in a classroom environment, given SH-2.
Standard:	Described a unit's casualty evacuation process IAW FM 7-10 and CALL Newsletter 97-14 (SH-2).

Learning Step/ Activity (LS/A) 1, ELO 2

To complete the learning activity, you must--

- Read ELO 2 above.
- Read Student Handout 2.
- Complete questions 16 thru 33.
- Compare your responses with the suggested solution found in the solution/discussion to LE-1 (Appendix B).
- If your response does not agree with the answer in the solution/discussion review the lesson material.

ELO 3

Action:	Determine casualty evacuation request procedures.
Conditions:	As a first sergeant in a classroom environment, given SH-3.
Standard:	Determined casualty evacuation request procedures IAW FM 8-10-6 (SH-3).

Learning Step/ Activity (LS/A) 1, ELO 3

The complete the learning activity, you must--

- Read ELO 3 above.
- Read Student Handout 3.
- Complete questions 34 thru 41.
- Compare your responses with the suggested solution found in the solution/discussion to LE-1 (Appendix B).
- If your response does not agree with the answer in the solution/discussion review the lesson material.

SECTION IV SUMMARY

Review/ Summarize Lesson

The purpose of this lesson is to familiarize you with the casualty operations procedures in different types of units. There is no set way to accomplish this mission other then what is in the tactical SOPs and OPORDs. This lesson covered how to identify casualty evacuation operations, a unit's casualty evacuation process, and the procedure to request casualty evacuation.

Check on Learning

The lesson exercise in Appendix B serves as the check on learning.

Transition to Next Lesson

None.

SECTION V STUDENT EVALUATION

Testing Requirements

Before entering Phase II FSC-TATS, you will receive the end of Phase I Performance Examination that will include questions based on material in this lesson. On that examination, you must answer at least 70 percent of the questions correctly to achieve a GO.

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SECTION VI QUESTIONNAIRE

Directions Complete the following actions:

- Enter your name, your rank, and the date you complete this questionnaire.

Name:	Rank:	Date:

- Answer items 1 through 6 below.
- Fold the questionnaire, so the address for USASMA is visible.
- Print your return address, add postage, and mail.

Note: Your response to this questionnaire will assist the Academy in refining and improving this course. When completing the questionnaire, answer each question frankly. Your assistance helps build and maintain the best curriculum possible.

Item 1	Do you feel you have met the learning objectives of this lesson?
Item 2	Was the material covered in this lesson new to you?
Item 3	Which parts of the lesson were most helpful to you in learning the objectives?
Item 4	How could we improve the format of this lesson?
Item 5	How could we improve the content of this lesson?
Item 6	Do you have additional questions or comments? If you do, please list them here. You may add additional pages if necessary.

CMDT USASMA
ATTN ATSS DCF FSC TATS
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Appendix B

Index of Lesson Exercises and Solutions

This Appendix Contains

This Appendix contains the items listed in this table--

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LESSON EXERCISE 1

CASUALTY EVACUATION

Reference Materials/ Solutions	You may use any reference material to answer the questions. Do not refer to the solution until after you complete the items in this lesson exercise (LE). Select the correct answer or write your answers in the space provided.

General	This is a self-graded exercise. It should take you approximately 45 minutes to complete the exercise. It should take you approximately 15 minutes to self-grade the LE using the Solution to Lesson Exercise (SLE)

Item 1. What is the definition of a casualty evacuation?

Item 2. Which evacuation procedure includes enroute care by medical personnel?

A. MEDEVAC.
B. CASEVAC.
C. Casual evacuation.
D. Routine Evacuation

Item 3. What are the disadvantages of using utility and cargo aircraft in the casualty evacuation role?

A. Commanders can divert the aircraft from other missions to aid evacuations.
B. Cargo aircraft cannot transport casualties to the MTF in a timely manner.
C. There is no enroute medical care for casualties.
D. Utility aircraft cannot transport casualties over a rough terrain.

Item 4. Your commander wants you to accompany him while he visits some soldiers that are in post-operative treatment. Which level of care medical facility would you go to visit the soldiers?

A. Level I.
B. Level II.
C. Level III
D. Level IV.

Item 5. What does Level I medical treatment include?

A. Care includes treatment at a medical treatment facility.
B. Care includes medical facility staffed and equipped to provide initial wound surgery.
C. Care includes the brigade medical clearing company.
D. Care includes individual care (self-aid, buddy aid, and combat lifesaver).

Item 6. At the company level, who is normally responsible for CASEVAC coordination?

A. Platoon sergeant and squad leader.
B. First sergeant and XOs
C. Squad leader and XOs.
D. Commander and platoon leader.

Item 7. What is the ambulance exchange point (AXP)?

A. A point from where casualties are transferred from the Bn to the Bde ambulances.
B. A point where casualties are moved from the Bn MAS and FAS to the FSMC.
C. It is a level II treatment facility.
D. It is a medical facility in EAC.

Item 8. In order to plan casualty evacuation, you, as the first sergeant need to know the capabilities of the utility and cargo helicopters. What are the three different configurations available in a CH-47 for casualty evacuation?

A. Litter configuration, seats up, seats folded.
B. Seats folded, Seats down, seats extended.
C. Seats up, seats down, seats extended.
D. Seats folded, seats down, litter configuration.

Item 9. Your commander wants you to request medical support using utility helicopters. What consideration must you take into account while requesting CASEVAC operations?

Item 10. What is the mission of the casualty system?

Item 11. As the first sergeant, what type of casualties should your unit report?

A. All casualties, including all contractors and enemy wounded.
B. All casualties, excluding DoD civilians.
C. All casualties, including local nationals.
D. All casualties including DoD civilians.

Item 12. All persons with the knowledge of a casualty will report to their chain of command using DA Forms 1155/1156. Who is responsible for initiating the casualty information flow?

A. The executive officer.
B. The platoon sergeant.
C. The commander.
D. The squad leader.

Item 13. Casualty operations management requires specific information. What are the casualty information requirements?

Item 14. Commanders should ensure that all soldiers and civilians understand that casualty information is confidential and should process the information only through official channels. The information is assigned the protective marking of For Official Use Only (FOUO). When is the removal of the FOUO protective marking authorized?

A. Not until verification of next of kin occurs.
B. As soon as recovery of the casualty occurs.
C. As soon as casualty evacuation occurs.
D. As soon as marking of the casualty position occurs.

Item 15. How can you, as the first sergeant, ensure the confidentiality and sensitivity of casualty information?

Item 16. Personnel services include strength accounting; casualty reporting; replacement procedures; personnel records maintenance; personnel actions, such as awards, promotions and reductions, and classifications and reclassifications; and religious support. What actions is the company responsible for?

A. All actions.
B. Only for casualty reporting or requesting personnel
C. Personnel records maintenance.
D. Awards and promotions and reductions.

Item 17. A requirement for a casualty report, DA Form 1156 (Figure 8-3), exists when a casualty occurs or as soon as the tactical situation permits. Who usually fills out the form and what information does he/she report?

Item 18. Which form do you use to report missing or captured soldiers or when you do not recover remains?

A. DD Form 1156.
B. DD Form 1155.
C. DA Form 1155.
D. DA Form 1255.

Item 19. At company level, there are three levels of health services support addressed, what are the three areas?

A. Preventive medicine, first aid, medical evacuation.
B. Preventive medicine, medical treatment, and evacuation of casualties.
C. Preventive medicine, buddy aid, and medical treatment.
D. Preventive medicine, medical treatment, and replacement operations.

Item 20. How many combat lifesavers should an infantry squad have trained to assist the medic in treating and evacuating casualties?

A. One
B. Two.
C. Three.
D. Four.

Item 21. During the fight, you usually leave casualties where they receive initial treatment (self-aid, buddy-aid). What action should you take as soon as the situation allows?

A. Move casualty to the battalion collection point.
B. Move casualty to the ambulance exchange point.
C. Move casualty to the platoon collection point.
D. Evacuate casualty to the rear echelon.

Item 22. An effective technique, particularly during an attack, is to task-organize a logistics team under the 1SG. What would be the responsibility of this task force?

Item 23. In rough terrains, how would you accomplish the evacuation of casualties to the battalion aid station?

Item 24. In the casualty evacuation process, what should the unit SOP or OPORD cover? What should they specify?

Item 25. In reference to casualty evacuation, what should paragraph 4 of the OPORD provide?

Item 26. In the CALL newsletter (97-14) article, "Company Casualty Evacuation: Planning for Success", what is the major cause for the high mortality rate and why?

Item 27. What should the composition of the company's area damage control team be?

A. An NCOIC with commo, several stretcher bearers, and one combat lifesaver.
B. An NCOIC with commo, three medics, and one combat lifesaver.
C. An NCOIC, Bn Aid station, and five stretcher bearers.
D. Two medics, several stretcher bearers, and two combat lifesavers.

Item 28. Who designates the location of the company casualty collection point (CCP)?

A. The first officer in the area.
B. The XO.
C. The platoon leader.
D. The commander.

Item 29. The commander must maintain the flexibility to move this point at all times. Besides communication between all elements, what are four key points that should occur in order to make the shift successful?

Item 30. What are the minimum requirements to setup a CCP?

Item 31. What is the CCP NCOIC responsible for?

Item 32. Who is the key to a successful company casualty collection point operation? What is his/her role?

Item 33. What are three categories used to evaluate casualties?

Item 34. What is the difference in the formats used to request aeromedical evacuation and ground evacuation?

Item 35. Why is the unit evacuation plan essential to requesting evacuation?

Item 36. What are the unit responsibilities during a medical evacuation?

Item 37. What are the main differences in the wartime versus the peacetime medical evacuation requests?

Item 38. How do you transmit wartime medical evacuation requests?

A. Non-secure means.
B. Routine message traffic.
C. By secure means only.
D. By landline.

Item 39. In order to make a medical evacuation request, where will you find the primary and alternate communications channels to use?

A. In the unit evacuation plan.
B. In the unit contingency plan.
C. In the unit emergency plan.
D. In the unit garrison operations plan.

Item 40. What are the brevity codes used in line four (4), Special Equipment Required, of a medevac request and why is the code required?

Item 41. What are the brevity codes used during wartime in line six (6) of a medevac request?

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SOLUTION FOR LESSON EXERCISE 1
CASUALTY EVACUATION

Note: The answers to the questions are verbatim from the FMs. Passive voice and grammatical errors may exist.

Item 1. What is the definition of a casualty evacuation?

Answer: ***Casualty Evacuation.*** CASEVAC is defined as movement of casualties to initial treatment facilities and movement of casualties to MTFs in the combat zone. It does not include enroute care by medical personnel and implies that nonmedical assets (UH-60s or CH-47s) are being used to move casualties. CASEVAC should only be used when the unit has a large number of casualties (exceeding the ability of the MEDEVAC aircraft to carry) or MEDEVAC is not available.

Reference: SH-1, pg SH-1-1, para 6-1b, ELO-1.

Item 2. Which evacuation procedure includes enroute care by medical personnel?

Answer: A. ***Medical Evacuation.*** MEDEVAC is defined in FM 8-10-6 as the timely, efficient movement and enroute care by medical personnel of the wounded, injured, and ill persons, from the battlefield and other locations to MTFs.

Reference: SH-1, pg SH-1-1, para 6-1a, ELO1.

Item 3. What are the disadvantages of using utility and cargo aircraft in the casualty evacuation role?

Answer: C. ***Disadvantages of Using Utility and Cargo Aircraft in the Casualty Evacuation Role.***

(1) There is no enroute medical care for casualties and,

(2) Aircraft in the CASEVAC role are not protected under the Geneva Convention.

Reference: SH-1, pg SH-1-2, para 6-1e, ELO1.

Item 4. Your commander wants you to accompany him while he visits some soldiers that are in post-operative treatment. Which level of care medical facility would you go to visit the soldiers?

Answer: C. ***Level III.*** Care is rendered at a medical treatment facility staffed and equipped to provide resuscitation, initial wound surgery, and post operative treatment. Level III care includes corps CSH, contingency hospitals, fleet hospitals, and hospital ships.

Reference: SH-1, pg SH-1-3, para 6-2c, ELO1.

Item 5. What does Level I medical treatment include?

Answer: D. ***Level I.*** Care is provided by designated individuals or elements organic to combat and CS units. Emphasis is placed on those measures necessary to stabilize the patient and evacuate to the next level of care. Level I care includes individual care (self-aid, buddy aid, combat lifesaver) and battalion aid station care.

Reference: SH-1, pg SH-1-2, para 6-2a, ELO1.

Item 6. At the company level, who is responsible for CASEVAC coordination?

Answer: B. ***Company Level Care.*** Company **first sergeants** and XOs are normally given responsibility to coordinate CASEVAC for the company. The first sergeant ensures that combat lifesavers have the required equipment on hand, and that company transportation, if available, is prepared to move casualties.

Reference: SH-1, pg SH-1-3, para 6-3a, ELO1.

Item 7. What is the ambulance exchange point (AXP)?

Answer: A. ***Ambulance exchange point.*** An AXP is a location where casualties are transferred from the battalion to the brigade ambulances. AXPs will be designated in the OPORD under the service support annex. AXPs will be activated and deactivated based on the current situation on the battlefield. The brigade medical company will position ambulances from the ambulance platoon at the AXPs to accept casualties from the battalion. Evacuation will then be to the BSA.

Reference: SH-1, pg SH-1-4, para 6-3c(1), ELO1.

Item 8. In order to plan casualty evacuation, you, as the first sergeant need to know the capabilities of the utility and cargo helicopters. What are the casualty evacuation capabilities of the CH-47 in the following configurations?

Answer: D. CH-47s can be used for CASEVAC using several different configurations:

(1) Seats folded. With seats folded up, the number of casualties that can be transported is dependent on the type of casualty (ambulatory versus litter) and the severity of the injuries and wounds to the casualties.

(2) Seats down. With seats folded down, the lifting capacity for litter patients will be reduced. Ambulatory capabilities in this configuration will be 30 seated ambulatory casualties and others loaded on the floor, as directed by the aircrew.

(3) Litter configuration. CH-47s can be equipped with a litter kit. This kit gives the CH-47 the capacity to transport 24 litter patients. When set up in the litter configuration, the CH-47 seats are replaced with six tiers of litters, four litters high.

Note: The litter support kit of the CH-47 consists of the poles and supports only. Litters and tie- down straps must be provided by the supported unit. The litters must be provided by the medical assets belonging to the unit the CASEVAC aircraft are supporting.

Reference: SH-1-5, para 6-4a and b, ELO1.

Item 9. Your commander wants you to request medical support using utility helicopters. What consideration must you take into account while requesting CASEVAC operations?

Answer: ***Medical Support***. As defined, CASEVAC operations do not provide any enroute medical treatment. Commanders and medical personnel must consider this when determining if utility helicopters should be used to transport casualties.

Reference: SH-1, pg SH-1-8, para 6-6b, ELO1.

Item 10. What is the mission of the casualty system?

Answer: The mission of the casualty system is to record, report, verify, and process casualty information from unit level to HQDA; notify appropriate individuals; and provide casualty assistance to next of kin.

Reference: SH-1, pg SH-1-9, para 2nd para, ELO1.

Item 11. As the first sergeant, what type of casualties should your unit report?

Answer: D. Units report all casualties found on the battlefield, including DoD civilians, contract personnel, and military personnel from other U.S. Army units, other services, and allied forces. Units record casualties on Witness Statement/Casualty Feeder Reports (DA Forms 1155/1156). These reports are sent to battalion level without delay or as soon as the tactical situation permits.

Reference: SH-1, pg SH-1-10, 3rd para, ELO1.

Item 12. All persons with the knowledge of a casualty will report to their chain of command using DA Forms 1155/1156? Who is responsible for initiating the casualty information flow?

Answer: C. The commander of a unit in which a casualty occurs has responsibility for initiating the casualty information flow.

Reference: SH-1, pg SH-1-12, 5th para, 2nd line, ELO1.

Item 13. Casualty operations management requires specific information. What are the casualty information requirements?

Answer: Casualty operations management requires information from the following sources:

- Witness Statement/Casualty Feeder Reports (DA Forms 1155/1156) from the unit.
- Individual personnel information from the servicing PSB.
- Patient accountability status from medical facilities.
- Individual diagnosis and prognosis reports from medical facilities.
- Evacuation reports from medical facilities.
- Status of remains from MA collection points and mortuary sites.
- Straggler information from provost marshal channels.

Reference: SH-1, pg SH-1-13, 2nd para, ELO1.

Item 14. Commanders should ensure that all soldiers and civilians understand that casualty information is confidential and should process the information only through official channels. The information assigned is the protective marking of For Official Use Only (FOUO). When is the removal of the FOUO label authorized?

Answer: A. Casualty information is assigned the protective marking of For Official Use Only (FOUO) which may not be removed until verification that next of kin have been notified. Information on a soldier/civilian in a missing status will remain FOUO until the person is returned to military control or the FOUO protection is removed, IAW appropriate regulations.

Reference: SH-1, pg SH-1-14, 6th para, 3rd line, ELO1.

Item 15. How can you, as the first sergeant, ensure the confidentiality and sensitivity of casualty information?

Answer: All commanders, soldiers, and deployed civilians must be sensitized to the confidentiality of casualty information. Commanders must ensure that it is processed only through official channels. Commanders should integrate confidentiality and sensitivity of casualty information into formal training at all levels.

Reference: SH-1, pg SH-1-14, 6th para 1st, 2nd and last lines, ELO1.

Item 16. Personnel services include strength accounting; casualty reporting; replacement procedures; personnel records maintenance; personnel actions, such as awards, promotions and reductions, and classifications and reclassifications; and religious support. What actions is the company responsible for?

Answer: B. The company is responsible only for casualty reporting or requesting personnel actions.

Reference: SH-2, pg SH-2-1, para 8-13a, ELO2.

Item 17. A requirement for a casualty report, DA Form 1156 (Figure 8-3), exists when a casualty occurs or as soon as the tactical situation permits. Who usually fills out the form and what information does he/she report?

Answer: A casualty report, DA Form 1156 (Figure 8-3), is filled out when a casualty occurs or as soon as the tactical situation permits. This is usually done by the soldier's squad leader and turned in to the platoon sergeant who passes it along to the first sergeant. A brief description of how the casualty occurred, to include the place, time, and squad leader does not have personal knowledge of how the casualty occurred, he gets this information from any soldier who does.

Reference: SH-2, pg SH-2-1, para 8-13c, ELO2.

Item 18. Which form do you use to report missing or captured soldiers or when you do not recover remains?

Answer: C. DA Form 1155 (Figure 8-4), is used to report missing or captured soldiers or when remains are not recovered. The form is completed by the soldier with the most knowledge of the incident. This information is used to inform the soldier's next of kin and to provide a statistical base for analysis of friendly or enemy tactics. The commander writes a letter to the soldier's next of kin.

Reference: SH-2, pg SH-2-1, para 8-13c, ELO2.

Item 19. At company level, there are three levels of health services support addressed, what are the three areas?

Answer: B. At company level, health services support addresses three areas: preventive medicine, medical treatment, and evacuation of casualties.

Reference: SH-2, pg SH-2-4, Section V, Medical Support, ELO2.

Item 20. How many combat lifesavers should an infantry squad have trained to assist the medic in treating and evacuating casualties?

Answer: A. The unit SOP should call for at least one infantryman per squad to be trained as combat lifesavers to assist the medic in treating and evacuating casualties. Since aidmen and combat lifesavers cannot be everywhere on the battlefield, every soldier must be trained to provide basic first aid.

Reference: SH-2, pg SH-2-4, para 8-16, ELO2.

Item 21. During the fight, you usually leave casualties where they receive initial treatment (self-aid, buddy-aid). What action should you take as soon as the situation allows?

Answer: C. During the fight, casualties often are left where they received initial treatment (self-aid, buddy-aid). As soon as the situation allows, casualties are moved to the platoon collection point. They can then be evacuated directly to the battalion aid station or to the company collection point, which is designated by the commander during the OPORD.

Reference: SH-2, pg SH-2-5, para 8-17a, ELO2.

Item 22. An effective technique, particularly during an attack, is to task-organize a logistics team under the 1SG. What would be the responsibility of this task force?

Answer: These soldiers carry additional ammunition forward to the platoons and evacuate casualties to either the company or the battalion casualty collection point.

Reference: SH-2, pg SH-2-5, para 8-17 b, ELO2.

Item 23. In rough terrains, how would you accomplish the evacuation of casualties to the battalion aid station?

Answer: In rough terrain (or on patrols), casualties may be evacuated to the battalion aid station by litter teams, carried with the unit until transportation can reach them, or left at a position and picked up later.

Reference: SH-2, pg SH-2-5, para 8-17e, ELO2.

Item 24. In the casualty evacuation process, what should the unit SOP or OPORD cover? What should they specify?

Answer: They should cover the duties and responsibilities of key personnel; the evacuation of chemically contaminated casualties (on separate routes from noncontaminated); and the priority for manning key weapons and positions. They should specify preferred and alternate methods of evacuation and make provisions for retrieving and safeguarding the weapons, ammunition, and equipment of casualties.

Reference: SH-2, pg SH-2-5, para 8-17f, ELO2.

Item 25: In reference to casualty evacuation, what should paragraph 4 of the OPORD provide?

Answer: Paragraph 4, Service Support, of the OPORD must provide the following:

- Location of casualty collection points (battalion, company, company).
- Procedures and responsibilities for medical evacuation.
- Planned use of nonmedical transportation assets for evacuation.
- Procedures for treating and evacuating EPWs and civilian casualties.
- Communication nets for evacuation requests.
- A time when the evacuation mission will begin and the nonmedical soldiers can aid in collection and evacuation. This prevents combat power from being diverted from the mission.

Reference: SH-2, pg SH-2-6, paragraph 4 section, ELO2.

Item 26: In the CALL newsletter (97-14) article, "Company Casualty Evacuation: Planning for Success", what is the major cause for the high mortality rate and why?

Answer: **Primary causes** for the high mortality rate:

- Units take too long to evacuate the casualty.
- Improper transportation and treatment techniques.

Why? Failure to develop an integrated casualty evacuation plan that includes both medical treatment and evacuation from the point of injury to the medical company.

Reference: SH-2, pg SH-2-7, 2nd paragraph, ELO-2.

Item 27: What should the composition of the company's area damage control team be?

Answer: A. This team should consist of at least an NCOIC with communication, several stretcher bearers, and at least one combat lifesaver.

Reference: SH-2, pg SH-2-9, 1st paragraph after Note, ELO-2.

Item 28: Who designates the location of the company casualty collection point (CCP)?

Answer: D. The company commander must designate the location of the company CCP and resource it. The CCP is normally a static location. It is identified by the commander unit has casualties equally distributed throughout the company area.

Reference: SH-2, pg SH-2-10, 1st paragraph, ELO-2.

Item 29: The commander must maintain the flexibility to move this point at all times. Besides communication between all elements, what are four key points that should occur in order to make the shift successful?

Answer: The key to making this shift occur smoothly is communication between all elements.

1. Every soldier in the unit needs to ***know*** where the collection point is and ***rehearses*** moving to it prior to the event.
2. The commander must ensure that this rehearsal is conducted based on how the unit will actually transport the casualty to the medical company. Imagine walking the ground to the medical company at night as part of a four-soldier litter team carrying a casualty.
3. Identify soldiers who can carry a litter patient.
4. The commander must conduct this rehearsal both day and night, in Mission-Oriented Protective Posture (MOPP) IV, and carrying a simulated casualty.

Reference: SH-2, pg SH-2-10, 2nd para, ELO-2.

Item 30: What are the minimum requirements to setup a CCP?

Answer: Minimum requirements for a **CCP** are:

1. An NCOIC.
2. Communication with the company command post.
3. An evacuation vehicle with litters and a combat lifesaver.

Reference: SH-2, pg SH-2-10, 3rd paragraph, ELO-2.

Item 31: What is the CCP NCOIC responsible for?

Answer: **The NCOIC:**

1. Orchestrates the flow of casualties.
2. Collects and transmits the required casualty information to the company command post.
3. Must understand what data the commander requires.
4. Capability to call for additional assistance based on the number of casualties.

References: SH-2, pg SH-2-10, 4th paragraph, ELO-2.

Item 32: Who is the key to a successful company casualty collection point operation? What is his/her role?

Answer: The combat lifesaver is the key to a successful company casualty collection point operation. An observation at the NTC shows that many noncritical casualties are transported to the medical company before their more seriously injured comrades. This action results with soldiers dying of their wounds while waiting for transportation, simply because the unit did not locate them first. This is why the combat lifesaver's role at the casualty collection point is to triage the casualties, prep, and prioritize them for movement to the medical company.

Reference: SH-2, pg 2-11, 2nd paragraph, ELO-2.

Item 33: What are three categories used to evaluate casualties?

Answer: One technique is to evaluate casualties based on the following three categories: (See SH-3-2 for a definition of the following categories).

- urgent
- priority
- routine

Reference: SH-2, pg SH-2-11, 3rd paragraph, ELO-2.

Item 34. What is the difference in the formats used to request aeromedical evacuation and ground evacuation?

Answer: None: The same format used to request aeromedical evacuation is also used for requesting ground evacuation.

Reference: SH-3, pg SH-3-1, para 7-1, ELO-3.

Item 35: Why is the unit evacuation plan essential to requesting evacuation?

Answer: The unit evacuation plan is essential to requesting evacuation because it identifies—

- Primary and alternate channels to be used in submitting medical evacuation request.
- Primary and alternate evacuation routes to be used.
- Means of evacuation (type of transport such as litter, ground ambulance, or air ambulance) to be used.
- Location of the destination MTF, if predesigned.

Reference: SH-3, pg 3-1, para 7-2, ELO-3.

Item 36: What are the unit responsibilities during a medical evacuation?

Answer: A decision to request medical evacuation places certain responsibilities on the requesting unit in the overall evacuation effort. To prepare for and assist during evacuation, the unit must:

a. Ensure that the tactical situation permits successful evacuation.

b. Have an English-speaking representative at the pickup site when evacuation is requested for non-US personnel.

c. Ensure that patients are ready for pickup when the request is submitted and provide patient information, as required.

d. Receive backhauled medical supplies and report the type, quantity, and where they are delivered.

e. Move patients to the safest aircraft approach and departure point or AXP if they are to be evacuated by air. Ensure that ground personnel are familiar with the principles of helicopter operations.

The ground crew—

- Selects and prepares the landing site.
- Loads and unloads the helicopter according to the pilot's instructions.
- Briefs the pilot on the position of enemy troops and directs him to other units in the area, if asked.
- Guides the helicopter using hand signals during landing and takeoff when the tactical situation permits.
- Marks friendly positions when armed helicopter escort is provided.

Reference: SH-3, pg SH-3-2, para 7-4.

Item 37: What are the main differences in the wartime versus the peacetime medical evacuation requests?

Answer: a. Several differences exist between the wartime and the peacetime medical evacuation request formats and procedures. The wartime request format is shown in Table 7-1. The peacetime request form differs in two line item areas.

- Line 6 changed to number and type of wound, injury, or illness (two gunshot wounds and one compound fracture). If serious bleeding is reported, the patients blood type should be given, if known.

- Line 9 changed to description of terrain (flat, open, sloping, wooded). If possible, include relationship of landing area to prominent terrain features.

b. Security is another basic difference between wartime and peacetime requesting procedures. Under all nonwar conditions, the safety of US military and civilian personnel outweighs the need for security, and clear text transmissions of medical evacuation requests are authorized. During wartime, the rapid evacuation of patients must be weighed against the importance of unit survivability.

Reference: SH-3, pg SH-3-3, para 7-5c and d, ELO-3.

Item 38: How do you transmit wartime medical evacuation requests?

Answer: C. Wartime medical evacuation requests are transmitted by secure means only.

Reference: SH-3, pg SH-3-3, para 7-5d, ELO-3.

Item 39: In order to make a medical evacuation request, where will you find the primary and alternate communications channels to use?

Answer: A. The primary and alternate channels to use are specified in the unit evacuation plan.

Reference: SH_3, pg SH-3-4, para 7-8, ELO-3.

Item 40: What are the brevity codes used in line four (4), Special Equipment Required, of a MEDEVAC request and why is the code required?

Answer: The brevity codes used in line four (4), Special Equipment Required, of a MEDEVAC request are:

A. None.

.

B. Hoist.

C. Extraction Equipment.

D. Ventilator.

The codes are required so that the equipment can be placed on board the evacuation vehicle prior to the start of the mission.

Reference: SH-3, pg SH-3-7, Table 7-1, block 4, ELO-3.

Item 41: What are the brevity codes used during wartime in line six (6) of a MEDEVAC request?

Answer: The brevity codes used during wartime in line six (6) of a MEDEVAC request are:

N—No enemy troops in area.

P__Possibly enemy troops in area (Approach with caution).

E—Enemy troops in area (Approach with Caution).

X—Enemy troops in area (Armed escort required).

Reference: SH-3, pg SH-3-8, Table 7-1, block 6, ELO-3.

Appendix C

Index of Student Handouts

This Appendix Contains

This Appendix contains the items listed in this table--

Title /Synopsis	Page(s)
SH-1, extracts from FM 1-113, Sep 1997	SH-1-1 thru SH-1-16
SH-2, extracts from FM 7-10 Dec 1990 and CALL Newsletter 97-14	SH-2-1 thru SH-2-11
SH-3, extracts from FM-8-10-6 Apr 2000	SH-3-1 thru SH-3-12

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STUDENT HANDOUT 1

This student Handout Contains Eight pages extracted from (Chapter 6) material from FM 1-113, Utility and Cargo Helicopter Operations (Sep 1997) and eight pages (Chapter 3) from FM 12-6, Personnel Doctrine (Dec 1994).

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FM 1-113

CHAPTER 6

CASUALTY EVACUATION OPERATIONS

6-1. GENERAL

Commanders of medical units in a theater of operations use their resources to effectively evacuate and treat sick, injured, and wounded soldiers. Whether a soldier survives when wounded on the battlefield often depends on the time it takes to receive treatment. Quick responsive care is essential to protecting the force. Under current force structures, corps medical brigades are equipped with an evacuation battalion, each with 3 to 5 air ambulance companies with 15 UH-60s or UH-1s. Corps medical brigades may be augmented by attached air ambulance detachments and companies from the reserve component. The corps commander will task organize these air ambulances in direct support to division and ACR level on a priority basis. For planning purposes, division commanders can expect a company of MEDEVAC helicopters to be in direct support of the division. The air ambulance company will provide the division with responsive MEDEVAC support. However, during high tempo combat operations it may become necessary to reinforce the supporting MEDEVAC unit. If the situation requires movement of a large number of casualties, or if the force commander believes that reinforcing existing MEDEVAC assets is necessary, he may elect to use utility and cargo helicopters to move casualties to a treatment center. This chapter discusses the use of utility and cargo helicopters for CASEVAC.

a. *Medical Evacuation*. MEDEVAC is defined in FM 8-10-6 as the timely, efficient movement and enroute care by medical personnel of the wounded, injured, and ill persons, from the battlefield and other locations to MTFs. The term MEDEVAC refers to both ground and air assets. Divisions are equipped with both ground and air MEDEVAC assets.

b. *Casualty Evacuation.* CASEVAC is defined as movement of casualties to initial treatment facilities and movement of casualties to MTFs in the combat zone. It does not include enroute care by medical personnel and implies that nonmedical assets (UH-60s or CH-47s) are being used to move casualties. CASEVAC should only be used when the unit has a large number of casualties (exceeding the ability of the MEDEVAC aircraft to carry) or MEDEVAC is not available.

c. *Casualty Evacuation Support for Operations*. Use of CASEVAC aircraft for combat operations will be determined by the force commander. He should always request the use of MEDEVAC aircraft first. If current MEDEVAC support is insufficient to meet his requirements for evacuation of casualties, he should request CASEVAC support from the aviation brigade. If necessary, requests to use utility helicopters for CASEVAC operations will be made through the division G3. MEDEVAC aircraft that are DS to a division will receive their missions through the DMOC. The DMOC is responsible for

airspace control measures and mission planning for MEDEVAC assets. Utility and cargo aircraft conducting CASEVAC support will not be controlled by the DMOC; however, coordination should be made between the aviation brigade and the DMOC for deconfliction of aircraft evacuating casualties. Normally, utility and cargo helicopters will be task organized in a DS role no lower than brigade level. If task organized at division level, these assets will be under the control of the main support clearing company, which locates in the division support area. If under the control of a brigade, the aircraft may be under the control of either the FSMC or the FSB SPO. In either case, the ground commander requesting CASEVAC support must understand that CASEVAC support provides transportation for casualties and does not provide any care enroute to the treatment facility.

d. ***Advantages of Using Utility and Cargo Aircraft in the Casualty Evacuation Role.***

(1) The aircraft's speed and range make it possible to move casualties by air relatively long distances in a short period of time.

(2) Helicopters can move patients quickly over rough terrain and get into areas inaccessible to ground ambulances.

(3) Because of the range and speed, casualties can be transported to the MTF that can best deal with the patient's condition.

(4) Utility and cargo aircraft can be diverted from other missions, making them available immediately.

e. ***Disadvantages of Using Utility and Cargo Aircraft in the Casualty Evacuation Role.***

(1) There is no enroute medical care for casualties.

(2) Aircraft in the CASEVAC role are not protected under the Geneva Convention.

6-2. LEVELS OF CARE

There are four levels of treatment that have a direct impact on patients as they are treated and evacuated from the FLOT to higher level care facilities. Utility helicopter assets can expect to transport patients between levels I and II. Levels III and IV transport will most likely be accomplished by the corps air ambulance company.

a. ***Level I.*** Care is provided by designated individuals or elements organic to combat and CS units. Emphasis is placed on those measures necessary to stabilize the patient and evacuate to the next level of care. Level I care includes individual care (self-aid, buddy aid, combat lifesaver) and battalion aid station care.

b. *Level II*. Care is rendered at a medical clearing station. Here the casualty is examined and wounds and status are evaluated to determine the treatment and evacuation precedence. Level II care includes the brigade medical clearing company, the division medical company, and corps medical assets.

c. *Level III*. Care is rendered at a medical treatment facility staffed and equipped to provide resuscitation, initial wound surgery, and post operative treatment. Level III care includes corps CSH, contingency hospitals, fleet hospitals, and hospital ships.

d. *Level IV*. In level IV care the patient is treated in a hospital staffed and equipped for general and specialized medical procedures.

6-3. BATTLEFIELD CASUALTY EVACUATION STRUCTURE

Evacuation of casualties on the battlefield begins with the individual unit. The tiered MEDEVAC system begins at company level. Each successive level provides more life sustaining care. Utility helicopters will interact with this system to ensure that casualties are moved from the fight to medical aid as quickly as possible. Figure 6-1 shows the division medical structure.

a. *Company Level Care*. Company **first sergeants** and Xos are normally given responsibility to coordinate CASEVAC for the company. The first sergeant ensures that combat lifesavers have the required equipment on hand, and that company transportation, if available, is prepared to move casualties.

b. *Battalion Level Care*. Each maneuver battalion contains a medical platoon. If the situation dictates, the battalion aid station may split into two treatment teams. One team is headed by the battalion surgeon and the other by the battalion physician's assistant. These two teams, called the MAS and FAS can operate independently for up to 24 hours. The medical platoon has an ambulance section that has the responsibility of going forward to the maneuver companies and picking up casualties. They transport these casualties from the company collection point to the battalion MAS or the battalion FAS. Battalions may be augmented with a team from the ambulance section of the brigade FSMC.

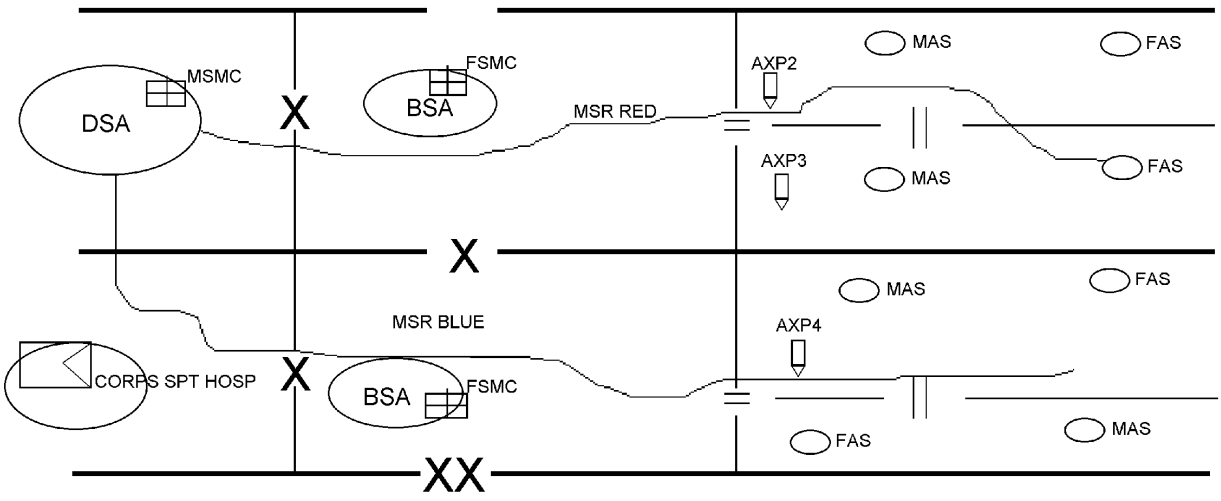

Figure 6-1. Division medical structure

(1) The MAS consists of the battalion surgeon, medics, and ambulances. At this location patients are evaluated, treated for immediate life sustaining care, and stabilized for transport to a higher level treatment facility. Equipment assigned to the MAS will vary depending on the type of battalion.

(2) The FAS is set up identical to the MAS, except that the primary care provider at the FAS is the battalion PA. It is equipped just as the MAS is and provides the same function.

(3) The MAS and FAS provide the battalion with two Level I medical care facilities. They normally operate in a "leapfrogging" mode. As the battle moves, the MAS and FAS will move to remain in support of the battalion. As one facility sets, the other will move forward of it (leapfrogging). This allows the maneuver battalion to sustain the tempo of the attack without loss of medical care. Additionally, if the battalion loses one aid station they continue to have a medical treatment facility.

c. ***Brigade Level Care.*** Casualties are moved from the battalion MAS and FAS to the FSMC located at the BSA. Battalion assets are responsible for transferring patients from the battalion aid stations to AXPs, where responsibility is passed to the brigade medical assets.

(1) ***Ambulance exchange point.*** An AXP is a location where casualties are transferred from the battalion to the brigade ambulances. AXPs will be designated in the OPORD under the service support annex. AXPs will be activated and deactivated based on the current situation on the battlefield. The brigade medical

company will position ambulances from the ambulance platoon at the AXPs to accept casualties from the battalion. Evacuation will then be to the BSA.

(2) ***Brigade forward support medical company.*** The FSMC is located in the BSA. It is a level II treatment facility. The FSMC will establish an LZ within the BSA specifically for casualty movement operations.

d. ***Division Level Care.*** The division medical care consists of the MSMC. This level II facility is located in the DSA. Like the medical company in the BSA, this company will establish a casualty LZ located in the vicinity of the medical hospital.

6-4. UTILITY AND CARGO HELICOPTER CASUALTY EVACUATION CAPABILITIES

a. ***UH-60s.*** UH-60s can provide CASEVAC support to the brigade and division. The number of casualties that can be transported by the UH-60 varies depending on aircraft con-figuration, such as seats in or seats out and other equipment that may be on board the aircraft. Additionally, the severity of the wounds of the casualties, as determined by the company combat lifesavers or battalion medics, may determine the ACL for the UH-60 for particular missions. UH-60s can expect to be used as far forward as possible to evacuate casualties to the battalion aid stations (MAS/FAS) or the FSB medical company.

b. ***CH-47s.*** CH-47s can be used for CASEVAC using several different configurations.

(1) ***Seats folded.*** With seats folded up, the number of casualties that can be transported is dependent on the type of casualty (ambulatory versus litter) and the severity of the injuries and wounds to the casualties.

(2) ***Seats down.*** With seats folded down, the lifting capacity for litter patients will be reduced. Ambulatory capabilities in this configuration will be 30 seated ambulatory casualties and others loaded on the floor, as directed by the aircrew.

(3) ***Litter configuration.*** CH-47s can be equipped with a litter kit. This kit gives the CH-47 the capacity to transport 24 litter patients. When set up in the litter configuration, the CH-47 seats are replaced with six tiers of litters, four litters high.

Note: The litter support kit of the CH-47 consists of the poles and supports only. Litters and tie-down straps must be provided by the supported unit. The litters must be provided by the medical assets belonging to the unit the CASEVAC aircraft are supporting.

6-5. BACKHAUL OF CASUALTIES DURING AIR ASSAULT OPERATIONS

a. ***General.*** During air assault operations, the AATF staff and aviation battalion plan for the use of lifting aircraft to backhaul casualties from the LZ. Additionally, the force

commander plans for MEDEVAC aircraft to support his operations. However, flowing MEDEVAC aircraft in during the air assault may become difficult and conflict with the ongoing operation. In this case, the AATFC and AMC will plan for CASEVAC operations by the assaulting aircraft. On air assaults with multiple lifts, the AATF plans for using the lifting aircraft to pick up casualties during successive lifts. On single lift air assaults, aircraft are designated to remain on standby for CASEVAC operations. These aircraft will normally stand by at a central location, most likely the PZ, FARP, or established holding area.

b. ***Mission Planning*****.** The backhaul of casualties on an air assault is a critical mission for the utility helicopters, and one that requires detailed planning to execute successfully. During the planning stages of the air assault, the AATF S3, S3 (air), AMC, aviation S3, and LNO must all be involved in the planning for this operation. If the AATF commander's intent is to backhaul casualties, then the planning must include the following considerations:

(1) ***Air assault task force commander's intent*****.** The AATFC must clearly state his intent for casualty backhaul during the air assault. The AMC must inform the commander of the tradeoff between using lifting aircraft for backhaul and continuing with the air assault. If the AATF takes casualties early in an air assault operation, it may become necessary to reduce the amount of lifting aircraft to accomplish backhaul of casualties. The AATFC should determine the number of aircraft he can bump from the air assault to pick up casualties. He may decide not to bump any and conduct all MEDEVAC or CASEVAC after the completion of the air assault, or he may designate aircraft in each lift (such as the last two aircraft) for backhaul of casualties from the LZ. It is imperative that the AMC understand the AATFC's intent on casualty backhaul and advise him on courses of action.

(2) ***Casualty locations*****.** The AATF should designate an area in the LZ for casualties to be brought. This will facilitate rapid movement and minimize ground time in the LZ for the aircraft. Since most air assaults will occur at night, it is critical that the casualty point be designated and that all members of the AATF know its location. The aircrews, as the arrive at the LZ, will be able to focus on the casualty point and be prepared to accept casualties.

(3) ***Signaling*****.** Night operations provide a significant challenge for casualty backhaul operations. Light signals should be planned so that aircraft arriving at the LZ can be prepared to accept casualties. For example, a flashlight or chem light coming from the designated LZ casualty location may indicate that there are casualties to be backhauled. This way the aircrews know that they must remain on the LZ and be prepared to accept casualties.

(4) ***Communications*****.** Once established in the LZ, communications on the CAN or a predesignated radio net can alert the flight of the necessity to backhaul casualties from the LZ.

(5) ***Designated area for dropping off casualties.*** The AATF commander must decide where to transport casualties if they occur during the air assault. During the planning process, the AATFC should develop a plan for the use of MEDEVAC helicopters. As the lifting aircraft drop off casualties, they can be loaded on to a MEDEVAC aircraft for transportation to higher level care facilities. Options include the PZ, the FSMC at the BSA, or another designated area. Considerations for selecting a casualty collection point should be--

(a) ***Casualty status.*** A site should be selected that is secure and has medical personnel ready to accept casualties.

(b) ***Aircraft availability.*** Aircraft conducting casualty backhaul will separate from the serial at some point. The AATF commander must be prepared to effect the bump plan if the aircraft carrying casualties do not return to the PZ for the next lift.

(c) ***Confusion.*** A casualty collection point should be selected so that it does not interfere with the air assault that is still in progress. Aircraft arriving at the PZ full of casualties may cause confusion on the PZ as troops are trying to load, and casualties are being unloaded from the aircraft.

(d) ***Aircraft rejoin.*** A site should be selected that allows the lifting helicopters to quickly drop off the casualty and return to the PZ to continue the tempo of the air assault operation.

6-6. CASUALTY EVACUATION MISSION PLANNING CONSIDERATIONS

CASEVAC mission planning must be detailed. The air movement planning considerations listed in Chapter 4 apply to CASEVAC operations as well. Units conducting CASEVAC missions should refer to this chapter to thoroughly plan and accomplish the mission. In addition, the following mission planning considerations should also be considered when preparing to conduct a CASEVAC mission:

a. ***Landing Zones/Pickup Zones.*** LZs /PZs for CASEVAC operations are the responsibility of the supported unit. For example, battalion aid stations are responsible for setting up the LZ/PZ for CASEVAC operations. LZ/PZ selection criteria for a CASEVAC LZ/PZ are location, marking, communications, capacity, and obstacles.

(1) ***Location.*** The LZ/PZ must be in close proximity to the aid station. Casualties may have to be carried by hand to the waiting aircraft. However, the LZ/PZ must be set up at a distance where it will not interfere with aid station operations. If possible, set the LZ/PZ up downwind from the aid station. This will help prevent blowing dust on the aid station. A minimum distance of 150 meters should be acceptable to keep aircraft from interfering with aid station operations.

(2) ***Marking.*** LZ/PZ markings must be visible from the air. During the day, marking of the LZ/PZ can be accomplished using a VS-17 panel, smoke, or signal mirror. If using a VS-17 panel, ensure it is visible from the air. At night, an inverted Y is used to designate the aircraft touchdown point. However, this may not be visible from the air. LZs/PZs should also have a far recognition signal, such as a swinging chem light or strobe light, to make the LZ/PZ easier to find.

(3) ***Communications.*** Air-to-ground communications should be maintained between the aircraft and the LZ/PZ. Effective communications will make movement times faster and assist the aircraft in locating the LZ/PZ.

(4) ***Capacity.*** LZ/PZ selection is based on the number of aircraft and type aircraft that will be used for the CASEVAC operation. The size determines how many aircraft can be landed at one time to load casualties.

(5) ***Obstacles.*** LZs/PZs should be free of obstacles. Obstacles such as cables, wires, antennas, large rocks, excessive slope, and large ruts can make the location unsuitable. Obstacles that cannot be cleared from the location should be marked. If communications are maintained with the aircrew, advisories should be provided to the crews as to hazards in the LZ/PZ.

b. ***Medical Support***. As defined, CASEVAC operations do not provide any enroute medical treatment. Commanders and medical personnel must consider this when determining if utility helicopters should be used to transport casualties.

c. ***Litters.*** Flight crews conducting CASEVAC missions must be told what to do with litters. The battalion aid stations need to have litters resupplied as casualties are evacuated to a higher level of care. Aircraft on CASEVAC missions may need to pick up litters at the drop off location and return them to the casualty PZ to keep the battalions resupplied. For example, once helicopters move casualties from a battalion aid station (MAS or FAS) to the BSA, the MAS or FAS may need the aircraft to backhaul litters for use in further CASEVAC missions. Flight crews must be briefed of this requirement and be prepared to execute litter backhaul to keep the battalion aid stations supplied with necessary litters.

d. ***Army Airspace Command and Control.*** If the division has MEDEVAC aircraft attached or OPCON to it, the DMOC will be responsible for planning the A^2C^2 measures that these aircraft will be using. Utility helicopters conducting CASEVAC missions in support of the medical companies of the BSA or DSA should check with the DMOC for the current MEDEVAC airspace structure. These procedures will also be specified in the airspace control order or SPINS.

FM 12-6 Chapter 3

CASUALTY OPERATIONS MANAGEMENT

This chapter describes the mission, proponency, doctrinal requirements, principles of support, unit and section responsibilities, manpower requirements, and personnel information requirements of the casualty system.

MISSION

The mission of the casualty system is to record, report, verify, and process casualty information from unit level to HQDA; notify appropriate individuals; and provide casualty assistance to next of kin.

Casualty operations includes casualty reporting, casualty notification, casualty assistance, line-of-duty determination, reporting status of remains, and casualty mail coordination.

Historical Perspective

"There's no more effective way of creating bitter enemies of the Army than by failing to do everything we can possibly do in a time of bereavement, nor is there a more effective way of making friends for the Army than by showing we are personally interested in every casualty which occurs." General of the Army, George C. Marshall, Army Chief of Staff, 1944.

PROPONENCY

The functional proponent for casualty operations is the Casualty and Memorial Affairs Operations Center (CMAOC), The Adjutant General Directorate, United States Total Army (USTA) PERSCOM.

AR 600-8-1, Army Casualty Operations (Draft), and AR 600-8-4, Line of Duty Investigations (Draft), provide policy and procedural guidance for managing casualty information and line of duty investigations.

DOCTRINAL REQUIREMENTS AND STANDARDS OF SUPPORT

Casualties can occur on the first day of a contingency operation. Thus, casualty managers from each echelon of command must deploy without delay.

Historical Perspective

On the eve of Operation Overlord, 6 June 1944, invading American units did not carry casualty management personnel on their wartime TDAs. Consequently, units went ashore on

D-Day with no or few trained soldiers to report the nearly 208,000 American soldiers wounded on the shores of Normandy Beach. The large volume of inaccurate reports resulting from this situation caused embarrassment to the War Department and unnecessary suffering of next of kin.

Personnel, medical, logistical, and provost marshal communities operate as a team in the casualty operations system.

Units report all casualties found on the battlefield, including DoD civilians, contract personnel, and military personnel from other U.S. Army units, other services, and allied forces. Units record casualties on Witness Statement/Casualty Feeder Reports (DA Forms 1155/1156). These reports are sent to battalion level without delay or as soon as the tactical situation permits.

Battalions and separate units may submit the DA Forms 1155/1156 to any PSB on the battlefield.

Battalions normally send this information to their supporting PSB. The time standard for casualty information processing is 24 hours from time of incident through casualty reporting channels to receipt at USTA PERSCOM.

Casualty information is frequently incomplete on the battlefield. This should not delay initial report submission. Updated casualty information is provided as it becomes available.

The casualty system must continually reconcile duty status whereabouts unknown, missing, missing in action and medical evacuation cases against other information sources to reach a final casualty status determination.

Casualty information flows up, across, and down the reporting chain to help account for soldiers and reportable civilians reported outside the normal reporting chain. A flow chart is shown at Figure 3-1.

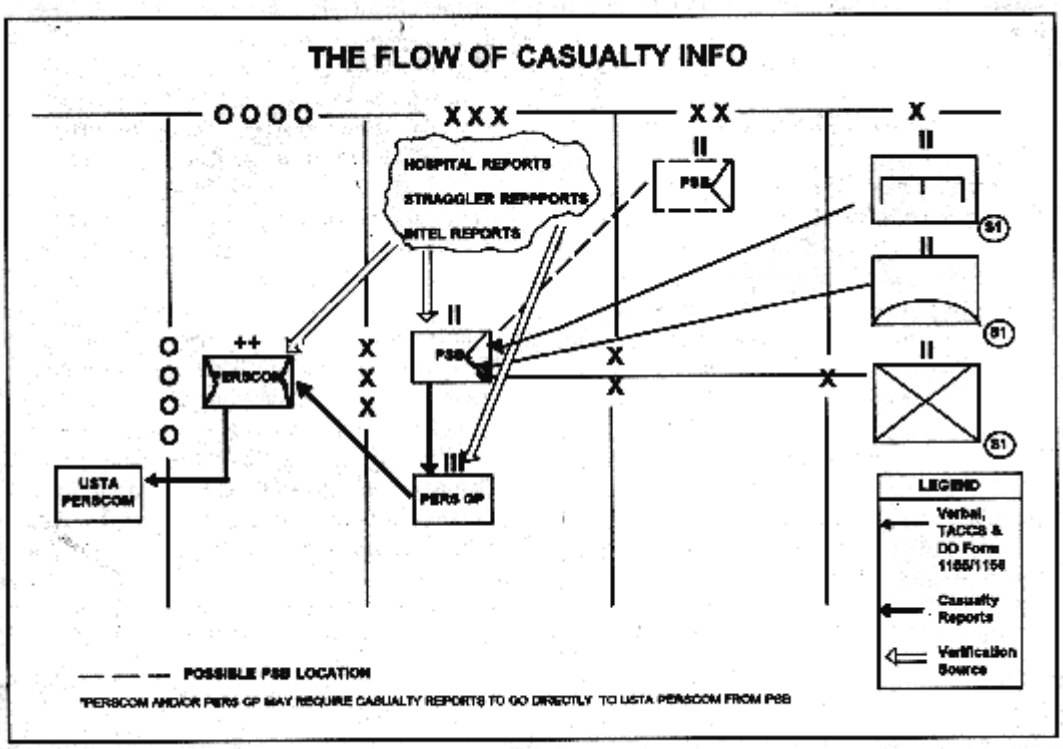

Figure 3-1

The medical evacuation system may move many injured soldiers from the battlefield to corps hospitals while the unit is still engaged. Therefore, communications and an electronic interface between the Theater Army Medical Management Information System (TAMMIS) and SIDPERS must be established to furnish timely casualty information. This information flows from the corps-level hospitals to the corps personnel management center (PMC). The corps PMC passes the casualty information by electronic transmission to the appropriate PSB for unit notification and report preparation, if required.

There is also a requirement for an interface between SIDPERS and mortuary affairs, provost marshal, and logistics systems such as the Mass Fatality Field Information Management System (MFFIS).

There is a requirement to account for all casualties, whether reportable or not, to exercise accurate strength reconciliation. SIDPERS 3.0 will provide SIDPERS/TAMMIS interface which will assist in patient accountability. The TAMMIS transaction recording admission to a corps support hospital signals a requirement to generate a SIDPERS arrival transaction to a UIC under control of the replacement company in direct support. The losing unit must also submit a departure transaction. This process removes patients from unit strength and provides patient accountability within a single unit.

The PMCs at corps/TAACOM and theater level must establish a casualty accounting data base and maintain a casualty status record. USTA PERSCOM developed interim casualty data base software for recording and transmitting casualty information. The personnel community will use

this software or software that is compatible with the USTA PERSCOM system for operations occurring before objective software is fielded.

Until an automated SIDPERS/TAMMIS interface is fielded, the personnel group commanders task subordinate commanders to station casualty liaison teams (CLTs) with all mortuary collection points and levels 3 and 4 medical facilities to include other service and host nation hospitals. This provides the interface between the personnel and medical systems. Casualty liaison teams consist of organic personnel. They are supplemented by borrowed military manpower such as soldiers returned to duty from the medical facility with physical profiles which prohibit return to their original units.

The Office of the Surgeon General is responsible for identifying the medical facilities within the sustaining base to be used to treat theater casual ties. Once identified, HQDA tasks the appropriate casualty area commanders to establish casualty liaison teams as necessary.

Casualty area commanders are responsible for notifying and providing casualty assistance to the next of kin of soldiers or civilians identified as casualties. They make notifications in compliance with regulatory guidance. USAR soldiers and soldiers recalled from retirement often serve as notification officers or survival assistance officers.

PRINCIPLES OF SUPPORT

The following paragraphs describe the principles of support of casualty operations management.

THE CASUALTY SYSTEM

All persons with the knowledge of a casualty will report to their chain of command using, DA Forms 1155/1156. The commander of a unit in which a casualty occurs has responsibility for initiating the casualty information flow. The unit submits the initial information to the battalion on DA Forms 1155/1156. The battalion forwards them to the PSB and sends a copy through its brigade to the division G1. Medical treatment facilities (MTFs) provide information on patient status and assist in personnel accounting, Casualty liaison teams provide an interface between medical facilities, mortuary affairs (MA) collection points, and the personnel group.

The PSB verifies casualty information against the data base and emergency data in the soldier's/civilian's deployment packet. The PSB adds appropriate information and prepares and forwards the casualty information to the personnel group (corps/TAACOM AG). From there it is forwarded to the theater PERSCOM (theater AG) and then to USTA PERSCOM. A Human Resources Division element (if deployed) assists in providing civilian casualty information (see Chapter 9).

USTA PERSCOM verifies information provided in the casualty report against available information systems. USTA PERSCOM then directs/coordinates notification actions through the appropriate casualty area commander who makes the notification and provides casualty assistance. A model of the casualty management network is at Figure 3-2.

CASUALTY INFORMATION MANAGEMENT						
FUNCTIONS/ TASKS	RESPONSIBLE AGENCY					
	BATTALION	BRIGADE	DIVISION	CORPS/TAACOM	THEATER	CONUS
REPORT AND RECORD CASUALTY INFORMATION	S1	S1	PSB/G1	PERS GROUP	THEATER PERSCOM	USTA PERSCOM
MANAGE CASE FILES	S1	S1	PSB	PSB	THEATER PERSCOM	USTA PERSCOM
MORTUARY AFFAIRS	S4	S4	MA TEAM (DISCOM)	MA COLL CO (CORPS SPT GRP/ TAACOM)	DCSLOG	ODCSLOG
PERSONAL EFFECTS	S4	S4	MA TEAM (DISCOM)	MA CO (CORPS SPT GRP/ TAACOM)	DCSLOG	ODCSLOG
LINE OF DUTY INVESTIGATION	S1	S1	G1	AG	THEATER PERSCOM	USTA PERSCOM
SURVIVOR ASSISTANCE	S1	S1	G1	AG	THEATER PERSCOM	USTA PERSCOM
POSTAL OPERATIONS	S1	S1	Postal Company	Postal Companies	Postal Company	MPSA/ USPS
COMMUNICATIONS	S3/Signal Officer	Signal Officer	Signal Bn	Signal Bde	Theater Signal Command	Information Systems Command

Figure 3-2

Although this chapter identifies the formal flow of casualty information, it must be recognized that casualty information will be collected from all available sources and reported though official channels as quickly as possible.

CASUALTY INFORMATION REQUIREMENTS

Casualty operations management requires information from the following sources:

- Witness Statement/Casualty Feeder Reports (DA Forms 1155/1156) from the unit.
- Individual personnel information from the servicing PSB.
- Patient accountability status from medical facilities.
- Individual diagnosis and prognosis reports from medical facilities.
- Evacuation reports from medical facilities.
- Status of remains from MA collection points and mortuary sites.
- Straggler information from provost marshal channels.

PERSONNEL ACCOUNTING

In addition to the previously described casualty system, the PSB must take extraordinary action to transfer personnel accountability for patients from the assigned unit to a patient accounting system. This is essential for two reasons: to remove soldiers and Army civilians no longer fit for duty from the unit's SIDPERS/ACPERS or off-line/manual data bases and to isolate and consolidate patient information for intensive accountability management.

Historical Perspective

The number of sick and wounded treated by Army hospitals during the Civil War was staggering. Large numbers of return-to-duty troops passed through "convalescent camps" in each of the major commands before returning to their units. An equally large number of troops were able to desert or take unauthorized leaves of absence because no system existed that would have accounted for their status and eventual return to their units.

In many instances, medical facilities and/or MA units will have information about casualties before the units have time to submit casualty reports. Pending automated system interface development, the personnel system must identify available medical facilities and establish a system to capture casualty information at those facilities.

CASUALTY LIAISON TEAMS

Managers of casualty operations must be proactive. They cannot afford to wait for units to submit casualty information. They must establish casualty liaison teams at all medical facilities to obtain casualty information as injured and ill persons arrive for treatment. Managers must also establish a liaison with mortuary affairs and provost marshal personnel.

Personnel groups and their subordinate units are responsible for the casualty liaison teams at level 3 and 4 (corps and above) MTFs, to include other services and host nation hospitals. They are also responsible for casualty liaison teams at MA collection points. Division G1s and brigade/battalion S1s are responsible for establishing a casualty liaison with level 1 and 2 (division and below) MTFs.

The casualty liaison team must get as much information as possible about each case and report it quickly to the appropriate PSB or next higher organization in the casualty reporting chain (even to the theater PERSCOM if necessary). Having received and processed the initial casualty report, the PSB must seek supplemental information from the injured or ill soldier's or civilian's unit.

CONFIDENTIALITY AND SENSITIVITY

All commanders, soldiers, and deployed civilians must be sensitized to the confidentiality of casualty information. Commanders must ensure that it is processed only through official channels. Casualty information is assigned the protective marking of For Official Use Only (FOUO) which may not be removed until verification that next of kin have been notified. Information on a soldier/civilian in a missing status will remain FOUO until the person is returned to military control or the FOUO protection is removed, IAW appropriate regulations. Emphasis on confidentiality and sensitivity of casualty information should be part of training on the DA Forms 1155/1156 and integrated into formal training programs at all levels.

Modern communications have increased the risk that family members will get casualty information from sources outside the official system. To combat this risk, casualty managers must employ all available means to get casualty information at the earliest possible moment.

Historical Perspective

During Operation Desert Storm, soldiers from divisions called their home stations to alert rear area personnel to casualties that their unit had sustained. The home station in turn called DA Casualty who in turn called the Casualty Area Command in Saudi Arabia. The incident had not yet been reported; no one in the casualty reporting chain had been alerted to the incident Reporting through unofficial channels causes confusion and creates unnecessary stress.

MORTUARY AFFAIRS AND PERSONAL EFFECTS

Overall policy for the disposition for remains and personal effects rests with HQDA, DCSPER. At CONUS installations, the supervision of the care and disposition of remains and the disposition of personal effects is a logistical function and may be accomplished by the installation Adjutant General. In OCONUS commands, the supervision of the care and disposition of personal effects is accomplished as a logistics function by the logistics commands and staffs.

During major military operations, the collection and evacuation of remains to a mortuary and the collection and evacuation of associated personal effects to a personal effects depot is a logistics responsibility under the supervision of logistics commands and staffs. The care and disposition of remains and the disposition of personal effects outside the area of military operations continues to be a personnel or logistics function depending on location. The CMAOC has the functional responsibility, during peace or war, for coordinating instructions for the permanent disposition of remains and archiving records and reports pertaining to the disposition of remains and personal effects.

RESPONSIBILITIES

Each management level in the casualty reporting chain will verify information as necessary to meet the 100 percent accuracy standard.

Historical Perspective

During Operation Desert Storm, a Casualty Area Command, based on unconfirmed reports, made erroneous notification to next of kin that two soldiers had been killed in a helicopter accident.

The following agencies have critical roles in establishing and operating the casualty operations management system for a contingency operation.

BATTALION

Battalion casualty management responsibilities include the following critical tasks:

- Ensure that all soldiers and civilians carry and are trained on DA Forms 1155/1156.
- Collect DA Forms 1155/1156 from units.

- Submit reports to the PSB.
- Send information copy to the brigade S1.
- Seek additional information from the medical support system on evacuated soldiers and Army civilians.
- Use all available information sources to determine the status of evacuated and missing soldiers and Army civilians; follow up continually on open cases to determine final status.
- Maintain a casualty log.
- Prepare letters of sympathy, and forward them to the division PMC.
- Accept and report changes to emergency data information.
- Coordinate information on mortuary affairs and personal effects disposition with the battalion S4.

STUDENT HANDOUT 2

This student Handout Contains Six pages extracted from (Section IV, para 8-13 through 8-17) material from FM 7-10, The Rifle Company (W/chg 1, Oct 2000) and five pages from CALL Newsletter, 97-14.

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FM 7-10 The Rifle Company

SECTION IV. PERSONNEL SERVICE SUPPORT

Expeditious handling of company paperwork is necessary for both efficiency and morale. The battalion PAC provides most of the company's administrative support. Information is passed from the company to the PAC through the S1 or the PAC supervisor. Though the system is informal, the information must be accurate and timely. Company administration consists of personnel services and replacement operations.

8-13. PERSONNEL SERVICES

These services include strength accounting; casualty reporting; replacement procedures; personnel records maintenance; personnel actions, such as awards, promotions and reductions, and classifications and reclassifications; and religious support.

a. The company is responsible only for casualty reporting or requesting personnel actions.

b. Based on local SOP, a strength accounting report is sent to battalion combat trains over the admin-log net detailing strength by officer, enlisted, and attached personnel. Data for this report must be gathered as quickly and accurately as possible because this critical information assumes increasing importance in decision-making as it is passed to the rear. Strength reports help determine the quantity of rations, water, and ammunition to send to each company. These reports are also used to analyze the company's strength, posture, and status. At higher echelons, they are used to determine which units receive priority when replacements arrive.

c. A casualty report, DA Form 1156 (Figure 8-3), is filled out when a casualty occurs or as soon as the tactical situation permits. This is usually done by the soldier's squad leader and turned in to the platoon sergeant who passes it along to the first sergeant. A brief description of how the casualty occurred, to include the place, time, and activity being performed, and who or what inflicted the wound is included. If the squad leader does not have personal knowledge of how the casualty occurred, he gets this information from any soldier who does. Pocket-size witness statements, DA Forms 1155 (Figure 8-4), are used to report missing or captured soldiers or when remains are not recovered. The form is completed by the soldier with the most knowledge of the incident. This information is used to inform the soldier's next of kin and to provide a statistical base for analysis of friendly or enemy tactics. The commander writes a letter to the soldier's next of kin.

The forms on the next two pages are not to scale. They were downloaded from the Reimer Library's Casualty Lesson.

FRONT

CASUALTY FEEDER REPORT *(AR 600-10)*	CONTROL NO.	CHECK APPLICABLE BOX ☐ HOSTILE ACTION ☐ NONHOSTILE ACTION

1. LAST NAME - FIRST NAME - MIDDLE INITIAL		
2. SERVICE NO.	3. GRADE	4. HOUR AND DATE OF INCIDENT
5. UNIT	6. GEOGRAPHICAL LOCATION *(nearby town)* AND GRID COORDINATES	

7. TYPE OF CASUALTY *(Check applicable box(es)*					
	KILLED IN ACTION		MISSING IN ACTION		WOUNDED OR INJURED IN ACTION
	DIED OF WOUNDS OR INJURIES		CAPTURED		LIGHTLY WOUNDED OR INJURED IN ACTION*
	DIED NOT AS RESULT OF HOSTILE ACTION		DETAINED		SERIOUSLY INJURED OR INJURED IN ACTION*
BODY RECOVERED YES ☐ NO ☐			INTERNED		SERIOUSLY INJURED NOT AS RESULT OF HOSTILE ACTION
BODY IDENTIFIED YES ☐ NO ☐			MISSING		LIGHTLY INJURED NOT AS RESULT OF HOSTILE ACTION
EVACUATED TO					
*To be indicated by medical personnel only.					

DA FORM 1156, 1 JUN 66 REPLACES EDITION OF 1 MAY 61, WHICH WILL BE ISSUED AND USED UNTIL EXHAUSTED.

BACK

8. WITNESSES WHO SAW INCIDENT OR IDENTIFIED REMAINS. *(Name, grade, service number and unit)* ***(THIS FORM DOWNLOADED FROM REIMER LIBRARY CASUALTY LESSON)***		
9. REMARKS *(Additional circumstances, any religious ministration performed, etc.)*		
10. FOR USE BY C.O. OR MED. OFF. *(only for casualties not the result of hostile action)* ☐ ☐ LINE OF DUTY: YES NO UNDETM	AUTHENTICATED BY *(CO or Med. Off.)*	VERIFIED BY (Pers. Off.)

UNIT	GRADE	SERVICE NO.
DATE	SIGNATURE OF PERSON PREPARING REPORT	

DA FORM 1156 (FIGURE 8-3)

FRONT

WITNESS STATEMENT ON INDIVIDUAL ***(AR 600-10)***	**CHECK APPLICABLE BOX** ☐ **MIS** ☐ **MIA** ☐ **CAP** ☐ **DET** ☐ **DEAD** ***(Remains not recovered)***

1. LAST NAME - FIRST NAME - MIDDLE NAME	**2. SERVICE NO.**

2A. SSN	**3. GRADE**	**4. DATE OF DEATH OR WHEN LAST SEEN**

5. ORGANIZATION	**6. GEOGRAPHICAL LOCATION** ***(Include grid coordinates and nearby town)***

7. IF ITEMS 1 AND 2 ARE UNKNOWN OR NOT POSITIVE, COMPLETE ITEMS LISTED BELOW:

AGE	**WEIGHT**	**HEIGHT**	**HAIR**	**EYES**	**RACE**

HOME TOWN	**CIVILIAN OCCUPATION**	**NICKNAME**

WAS HE MARRIED? ***(If so, give wife's name if known)***	**DID HE HAVE ANY CHILDREN?** ***(If so, give names if known)***

OTHER IDENTIFYING MARKS ***(such as tattoos or birthmarks)***	**OTHER PERSONS WHO MAY HAVE WITNESSED THIS INCIDENT OR HAVE FURTHER INFORMATION**

DA FORM 1155, 1 JUN 66 **REPLACES EDITION OF 1 JUN 61, WHICH WILL BE ISSUED AND USED UNTIL EXHAUSTED**

---

8. CIRCUMSTANCES SURROUNDING INCIDENT ***(If known, include cause of death or condition when last seen, and how identified)***

.

(THIS FORMS DOWNLOADED FROM REIMER LIBRARY CASUALTY LESSON)
FOR TRAINING PURPOSES

9. NAME OF PERSON MAKING STATEMENT	**10. SERVICE NO./SSN**	**11. UNIT**

12. DATE	**13. SIGNATURE**

DA FORM 1155

8-14 REPLACEMENT OPERATIONS

Integrating replacements into a company is important. A new arrival on the battle field may be scared and disoriented as well as unfamiliar with local SOPs and the theater of operations.

a. The company commander should meet them and welcome them to the unit. This will normally be a brief interview. The commander must have an SOP for reception and integration of newly assigned soldiers.

b. The platoon leader and platoon sergeant will welcome them to the unit, inform them of unit standards, and introduce them to their squad leaders.

c. The squad leader introduces the to the squad and briefs them on duty positions. He also ensures that each replacement has a serviceable, zeroed weapon; ammunition; MOPP gear; and other essential equipment. The in-briefing should cover squad and platoon recent, and planned activities.

d. The new arrival is told about important SOPs and special information concerning the area of operations. He may be given a form letter to send to his next of kin. The letter should tell them where to mail letters and packages, tell them how to use the Red Cross in emergencies, and introduce them to the chain of command.

SECTION V. MEDICAL SUPPORT

At company level, health services support addresses three areas: preventive medicine, medical treatment, and evacuation of casualties. Each rifle company has at least three aidmen from the battalion medical platoon's combat medic section attached to perform routine and emergency combat medical services.

8-15. PREVENTIVE MEDICINE

Emphasis is placed on prevention since soldiers may become combat ineffective from disease or nonbattle injury as well as from combat wounds. By understanding and applying the principles of field hygiene, preventing weather-related injuries, and paying attention to the soldiers' overall condition, some casualties may be prevented. (FMs 21-10 and 21-11.)

8-16. TREATMENT

Casualties are a certainty in war, and the leader must assure health service support is available. The platoon medic is trained to evaluate, triage, and treat casualties. The treatment of serious casualties usually means stabilizing the soldier until he can be evacuated to the battalion aid station. The unit SOP should call for at least one infantryman per squad to be trained as combat lifesavers to assist the medic in treating and evacuating casualties. Since aidmen and combat lifesavers cannot be everywhere on the battlefield, every soldier must be trained to provide basic first aid.

8-17. EVACUATION OF CASUALTIES

Effective casualty evacuation will provide a major increase in the morale of a unit. Casualties are treated where they fall (or under nearby cover and concealment) by a medic, combat lifesaver, or fellow soldier.

a. During the fight, casualties often are left where they received initial treatment (self-aid, buddy-aid). As soon as the situation allows, casualties are moved to the platoon collection point. They can then be evacuated directly to the battalion aid station or to the company collection point, which is designated by the commander during the OPORD. The unit SOP should address this activity and include marking casualties during limited visibility operations. Small, standard, or IR chemical lights work well for this purpose. Once the casualties have been collected, evaluated, and triaged, further evacuation to the battalion casualty collection point or aid station begins. Normally, the battalion aid station is collocated with the battalion casualty collection point.

b. An effective technique, particularly during an attack, is to task-organize a logistics team under the 1SG. These soldiers carry additional ammunition forward to the platoons and evacuate casualties to either the company or the battalion casualty collection point. The size of the team is determined by the leader during his estimate.

c. When the company is widely dispersed, the casualties may be evacuated directly from the platoon casualty collection point by vehicle or helicopter. Often, helicopter evacuation is restricted due to the enemy ADA threat. In some cases, the casualties must be moved to the company casualty collection point before evacuation. When the battalion's organic ambulances are not enough to move all the wounded, unit leaders may direct supply vehicles to "backhaul" casualties to the battalion aid station after supplies are delivered. In other cases, the platoon sergeant may direct platoon litter teams to carry the casualties to the rear.

d. Leaders must minimize the number of soldiers required to evacuate casualties. Casualties with minor wounds can walk or even assist carrying the more seriously wounded. Field expedient litters can be made by cutting small trees and putting the poles through the sleeves of buttoned BDU blouses. A travoise, or skid, may be used for casualty evacuation. This is a type of litter on which wounded can be strapped, and it can be pulled by one person. It can be locally fabricated from durable, rollable plastic on which tie-down straps are fastened. FM 7-20 discusses a SKEDS litter that is available for issue.

e. In rough terrain (or on patrols), casualties may be evacuated to the battalion aid station by litter teams, carried with the unit until transportation can reach them, or left at a position and picked up later.

f. Unit SOPs and OPORDs must address casualty evacuation in detail. They should cover the duties and responsibilities of key personnel; the evacuation of chemically contaminated casualties (on separate routes from noncontaminated); and the priority for

manning key weapons and positions. They should specify preferred and alternate methods of evacuation and make provisions for retrieving and safeguarding the weapons, ammunition, and equipment of casualties. Slightly wounded personnel are treated and returned to duty by the lowest echelon possible. Sick soldiers are evaluated by medics in the platoon and either treated or evacuated as necessary. Remains are kept covered, separated from the wounded, and evacuated by backhaul on supply vehicles as soon as possible. Casualty evacuation should be rehearsed like any other critical part of an operation.

From FM 7-8

The SOP should address casualty evacuation procedures in detail. It must clearly state that personal protective equipment remains with and is evacuated with the casualty. The casualty's weapon and equipment is retained by the company, redistributed as appropriate (ammunition, food, water, special equipment) or evacuated to the field trains by backhaul at the next LOGPAC. Machine guns, M203s, and other special weapons are never evacuated but are reassigned to their soldiers.

Paragraph 4, Service Support, of the OPORD must provide the following:

- Location of casualty collection points (battalion, company, company).
- Procedures and responsibilities for medical evacuation.
- Planned use of nonmedical transportation assets for evacuation.
- Procedures for treating and evacuating EPWs and civilian casualties.
- Communication nets for evacuation requests.
- A time when the evacuation mission will begin and the nonmedical soldiers can aid in collection and evacuation. This prevents combat power from being diverted from the mission.

Leaders must be prepared to treat and evacuate casualties. They must understand the plan for casualty evacuation and immediately begin to execute it once casualties occur.

COMPANY CASUALTY EVACUATION: PLANNING FOR SUCCESS

by CPT Robert Burks, SECOPS, NTC

CALL Newsletter 97-14

0430, Brigade Support Area, Mojavia

SPC Williams is jerked awake by explosions. He quickly rolls out of his cot. Trying to pull on his gear, he stumbles out of the tent. Barely three steps later, the concussion from an artillery shell exploding nearby knocks him to the ground. Williams screams as white-hot 152-mm artillery shell fragments tear through his body. Fighting to maintain consciousness, Specialist Williams attempts to call for help as he watches the confusion unfold around him. Under the blanket of darkness, the unit slowly tries to make sense out of the confusion that always follows an artillery attack. Meantime, still lying on the ground, waiting for medical treatment, SPC Williams drifts into unconsciousness as life slips from his body.

This is a routine event at the National Training Center. NTC trends show that logistics companies typically average 53 percent died of wounds rates in the Brigade Support Area. This rate is discouraging when you know that these companies are only 600 to 1,000 meters from the medical company.

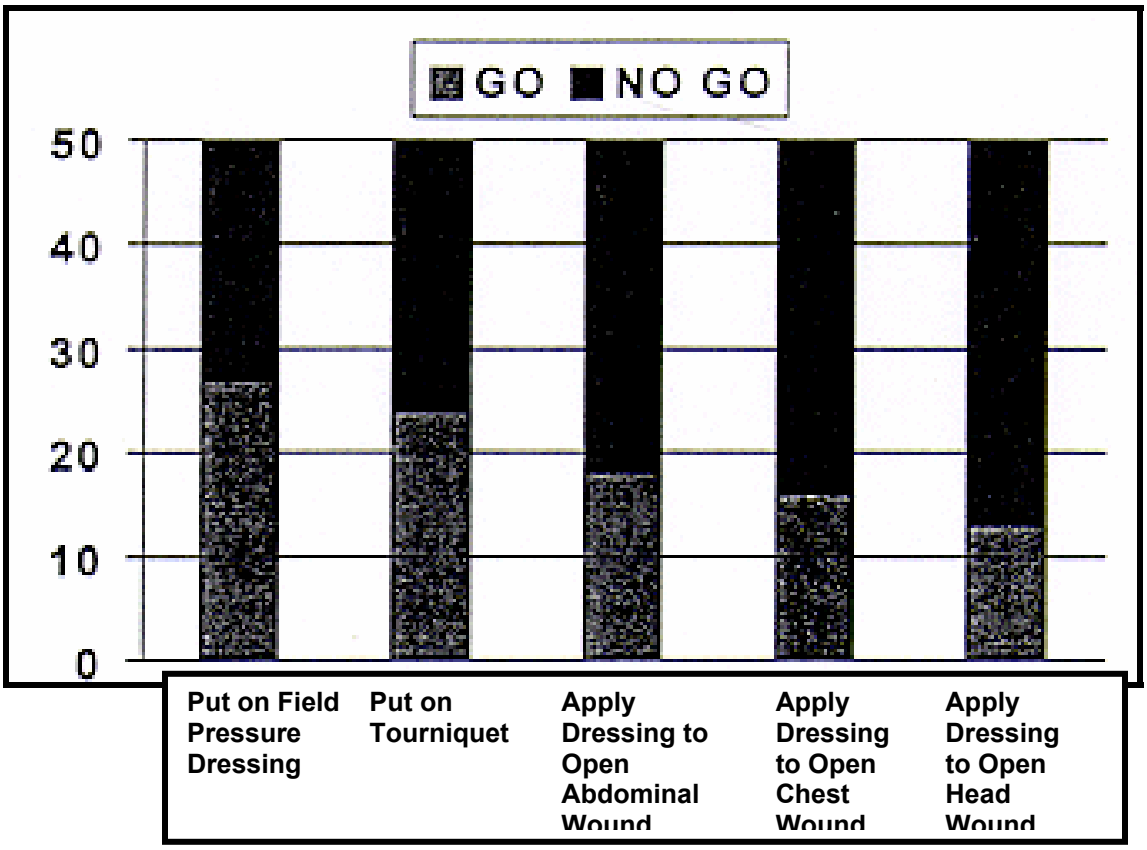
Primary causes for the high mortality rate:

1. Units take too long to evacuate the casualty.
2. Improper transportation and treatment techniques.

Why? Failure to develop an integrated casualty evacuation plan that includes both medical treatment and evacuation from the point of injury to the medical company.

The company commander must understand that he will take casualties. He must develop a company casualty evacuation plan that assigns responsibility for both treatment and evacuation for each individual soldier in the unit, the Area Damage Control (ADC) team and the company casualty collection point.

The commander's casualty plan must start with immediate treatment at the point of injury. When a casualty occurs during an attack, the first soldier on the scene to render assistance is normally the casualty's fighting position buddy. It is this soldier's responsibility to start the treatment process by conducting buddy aid at the point of injury. Trends at NTC indicate that logistics units are not training their soldiers in basic first aid. The unit must understand that this initial treatment is the first building block in a successful company medical plan. Depending on the nature of the attack, the unit may not be in a position to provide additional medical attention to the casualty for a prolonged period of time.



Depending on the nature of the attack, the unit may not be in a position to provide additional medical attention to the casualty for a prolonged period of time. The company commander/first sergeant must ensure all soldiers are trained to execute at least the first aid tasks found in STP 21-1-Soldiers Manual of Common Tasks.

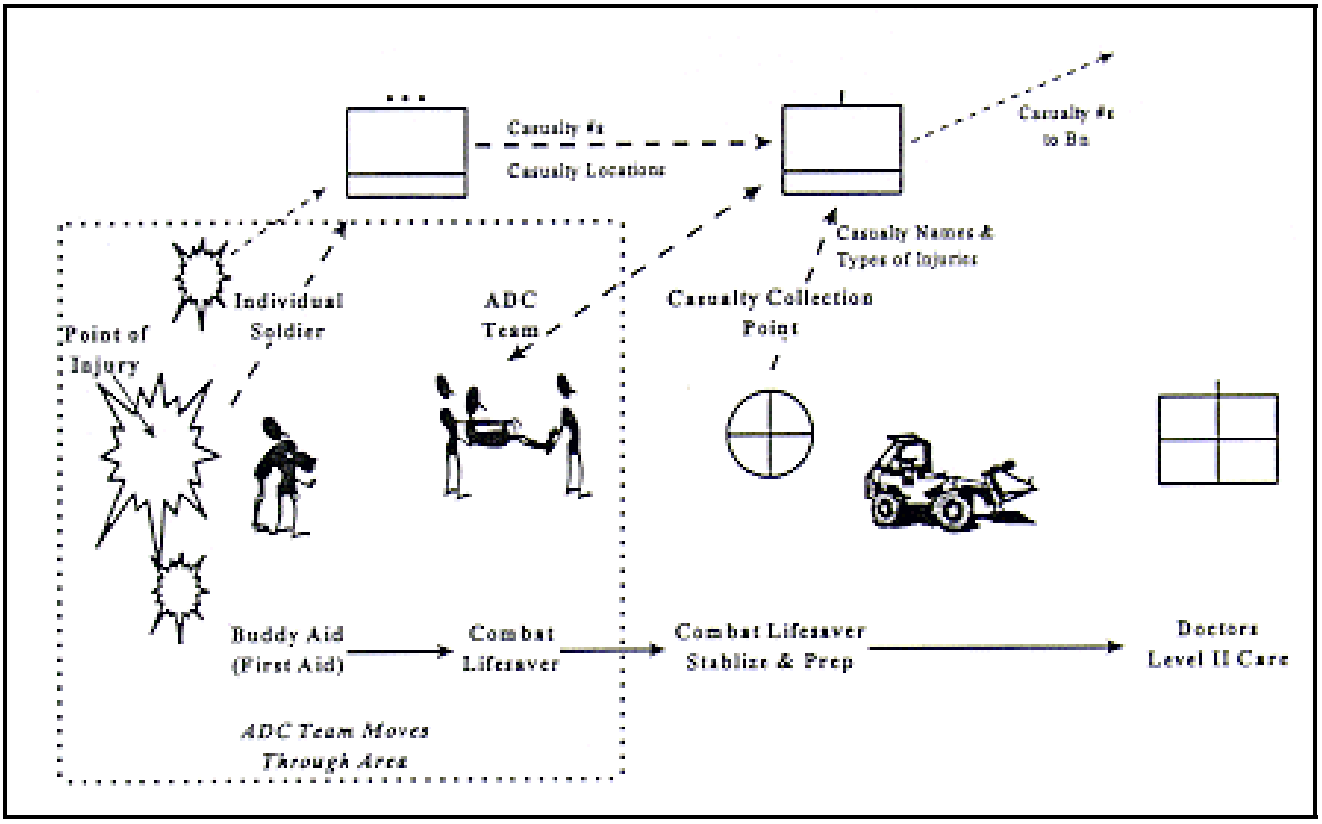
Buddy Aid

1. Complete initial treatment.
2. Mark the casualty's location so additional medical and evacuation help can easily locate the site.
3. Pass the casualty information through the chain to the company command post.

Unit

1. Mark location. Use anything from orange VS-17 panels to flags.
2. Develop and implement an SOP. Consider both day and night markings.
3. Ensure every soldier knows the marking system.
4. Ensure marking materials are readily available.

Note: Depending on the nature of the attack or type of injury, the casualty's buddy may be able to move the casualty directly to the casualty collection point. The unit's marking system becomes essential if the injury or situation does not allow the soldier to move the casualty.



The company's Area Damage Control (ADC) team will use this marking system to help rapidly identify casualties as it moves through the area. This team should consist of at least an NCOIC with communication, several stretcher bearers, and at least one combat lifesaver. The combat lifesaver is critical to the company's casualty evacuation plan. Each section or area in the company should have an assigned combat lifesaver that can move through the area and provide additional medical treatment. ***The commander must realize that the combat lifesaver is likely to be the first medically trained individual on the scene who has the capability to stabilize and prolong the casualty's life.***

NTC experience shows that logistics units not only fail to have sufficient combat lifesavers to support the company, they also typically fail to meet the standards for combat lifesaver bags outlined in the Combat Lifesaver Course, Edition Bravo. Combat lifesavers are combat multipliers. Units must train these soldiers. They must maintain their bags to standard and keep them handy at all times.

The ADC team begins working the movement of the casualty once the combat lifesaver finishes treatment. The ADC NCOIC must relay casualty numbers and locations to the company command post. This information is essential to ensure that the casualty collection point is

properly resourced. The company's ADC team must understand it is responsible for directing and assisting with the transportation of casualties to the company's Casualty Collection Point (CCP).

The company commander must designate the location of the company CCP and resource it. The CCP is normally a static location. It is identified by the commander in order; e.g., vicinity of the company command post. This concept works when the unit has casualties equally distributed throughout the company area. But the commander must maintain the flexibility to move this point to another area of the company if the casualty situation changes.

The key to making this shift occur smoothly is communication between all elements.

1. Every soldier in the unit needs to ***know*** where the collection point is and ***rehearses*** moving to it prior to the event.

2. The commander must ensure that this rehearsal is conducted based on how the unit will actually transport the casualty to the medical company. Imagine walking the ground to the medical company at night as part of a four-soldier litter team carrying a casualty.

3. Identify soldiers who can carry a litter patient.

4. The commander must conduct this rehearsal both day and night, in Mission-Oriented Protective Posture (MOPP) IV, and carrying a simulated casualty.

Minimum requirements for a **CCP** are:

1. An NCOIC.
2. Communication with the company command post.
3. An evacuation vehicle with litters and a combat lifesaver.

The NCOIC:

1. Orchestrates the flow of casualties.
2. Collects and transmits the required casualty information to the company command post.
3. Must understand what data the commander requires.
4. Capability to call for additional assistance based on the number of casualties.

The commander:

1. Must designate a vehicle to transport casualties to the medical company.
2. Station this vehicle at the casualty collection point.
3. Ensure it is ready to roll; i.e., completely downloaded.
4. Ensure that the unit understands the lift capability of the designated casualty evacuation vehicle.

EXAMPLE: A 5-ton cargo can carry litter casualties.

The unit:

1. Must have litters on hand to ensure proper transportation of the casualties. May be stretchers or any makeshift device -- cots for example.

2. Identify required items ahead of time instead of foraging for them while casualties wait.

The combat lifesaver is the key to a successful company casualty collection point operation. An observation at the NTC shows that many noncritical casualties are transported to the medical company before their more seriously injured comrades. This action results with soldiers dying of their wounds while waiting for transportation, simply because the unit did not locate them first. This is why the combat lifesaver's role at the casualty collection point is to triage the casualties, prep, and prioritize them for movement to the medical company.

One technique is to evaluate casualties based on the following three categories: (See SH-3-2 for a definition of the following categories).

- urgent
- priority
- routine

The collection point NCOIC coordinates transport for the casualties based on the seriousness of their injuries.

Cut transportation requirements and time: Consolidate the routine casualties, normally minor injuries. Have them walk escorted by a combat lifesaver to the medical company. This combat lifesaver must be different from the NCOIC's.

All leaders must understand that taking care of the unit's casualties will help build unit morale and confidence in the chain of command. Our soldiers will do anything their leaders ask if they know that the unit will do everything in its power to help them in the event they become a casualty. However, if logisticians allow the trend of 53 percent died of wounds rates to continue, our soldiers will question the sincerity of leaders who talk about taking care of soldiers.

The commander must stress the requirement for continuous training and rehearsal of the unit's casualty evacuation plan. Logistics units must use their available resources to provide the best possible care for its casualties. Soldiers must know their responsibilities and what is required of them to make the commander's plan work.

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STUDENT HANDOUT 3

This student Handout Contains	12 pages extracted, which includes the following, Chapter 7 (6 pages), Table 7-1 (4 pages) and Table I-1 (2 pages) material from FM 8-10-6, Medical Evacuation in a Theater of Operations Tactics, Techniques, and Procedures (14 Apr 2000).

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CHAPTER 7

EVACUATION REQUEST PROCEDURES

7-1. General

Procedures for requesting medical evacuation support must be institutionalized down to the unit level. Procedural guidance and standardization of request procedures are provided in this chapter. *The same format used to request aeromedical evacuation is also used for requesting ground evacuation.*

7-2. Unit Evacuation Plan

Before initiating any operation, a unit must have an evacuation plan in effect. The plan may be a standard TSOP or it may be designed for a particular operation. It can be published in various ways depending on the level of headquarters and the amount of detail required. For example, it may be in the form of verbal instructions at the squad or platoon level, a comment in the signal operation instructions (SOI), or a paragraph in the unit OPORD. The unit evacuation plan is essential to requesting evacuation because it identifies—

- Primary and alternate channels to be used in submitting the medical evacuation request.
- Primary and alternate evacuation routes to be used.
- Means of evacuation (type of transport such as litter, ground ambulance, or air ambulance) to be used.
- Location of the destination MTF, if predesignated.

This paragraph implements STANAGs 2087 and 3204, QSTAG 529, and Air STDs 44/36A and 61/71.

7-3. Determination to Request Medical Evacuation and Assignment of Medical Evacuation Precedence

The determination to request medical evacuation and assignment of a precedence is made by the senior military person present. This decision is based on the advice of the senior medical person at the scene, the patient's condition, and the tactical situation. Assignment of a medical evacuation precedence is necessary. The precedence provides the supporting medical unit and controlling headquarters with information that is used in determining priorities for committing their evacuation assets. For this reason, correct assignment of a precedence cannot be overemphasized; *overclassification remains a continuing problem*. Patients will be picked up as soon as possible, consistent with available resources and pending missions. The following are categories of precedence and the criteria used in their assignment:

a. *Priority I—URGENT* is assigned to emergency cases that should be evacuated as soon as possible and within a maximum of 2 hours in order to save life, limb, or eyesight, to prevent complications of serious illness, or to avoid permanent disability.

b. *Priority IA—URGENT-SURG* is assigned to patients who must receive far forward surgical intervention to save life and to stabilize them for further evacuation.

c. *Priority II—PRIORITY* is assigned to sick and wounded personnel requiring prompt medical care. This precedence is used when the individual should be evacuated within 4 hours or his medical condition could deteriorate to such a degree that he will become an URGENT precedence, or whose requirements for special treatment are not available locally, or who will suffer unnecessary pain or disability.

d. *Priority III—ROUTINE* is assigned to sick and wounded personnel requiring evacuation but whose condition is not expected to deteriorate significantly. The sick and wounded in this category should be evacuated within 24 hours.

e. *Priority IV—CONVENIENCE* is assigned to patients for whom evacuation by medical vehicle is a matter of medical convenience rather than necessity.

NOTE

The NATO STANAG 3204 has deleted the category of Priority IV—CONVENIENCE; however, it will still be included in the US Army evacuation priorities as there is a requirement for it on the battlefield.

7-4. Unit Responsibilities in Evacuation

A decision to request medical evacuation places certain responsibilities on the requesting unit in the overall evacuation effort. To prepare for and assist during evacuation, the unit must—

a. Ensure that the tactical situation permits successful evacuation.

b. Have an English-speaking representative at the pickup site when evacuation is requested for non-US personnel.

c. Ensure that patients are ready for pickup when the request is submitted and provide patient information, as required.

d. Receive backhauled medical supplies and report the type, quantity, and where they are delivered.

e. Move patients to the safest aircraft approach and departure point or AXP if they are to be evacuated by air. Ensure that ground personnel are familiar with the principles of helicopter operations. The ground crew—

- Selects and prepares the landing site.
- Loads and unloads the helicopter according to the pilot's instructions.
- Briefs the pilot on the position of enemy troops and directs him to other units in the area, if asked.
- Guides the helicopter using hand signals during landing and takeoff when the tactical situation permits.
- Marks friendly positions when armed helicopter escort is provided.

7-5. Types of Medical Evacuation Request Formats and Procedures

a. The medical evacuation request is used for requesting evacuation support for both air and ground ambulances.

b. There are two established medical evacuation formats and procedures—one for wartime use and one used in peacetime.

c. Several differences exist between the wartime and the peacetime medical evacuation request formats and procedures. The wartime request format is shown in Table 7-1. The peacetime request form differs in two line item areas.

(1) Line 6—changed to number and type of wound, injury, or illness (two gunshot wounds and one compound fracture). If serious bleeding is reported, the patient's blood type should be given, if known.

(2) Line 9—changed to description of terrain (flat, open, sloping, wooded). If possible, include relationship of landing area to prominent terrain features.

d. Security is another basic difference between wartime and peacetime requesting procedures. Under all nonwar conditions, the safety of US military and civilian personnel outweighs the need for security, and clear text transmissions of medical evacuation requests are authorized. During wartime, the rapid evacuation of patients must be weighed against the importance of unit survivability. Accordingly, wartime medical evacuation requests are transmitted by secure means only.

e. A medical evacuation request and mission completion record format is provided in Appendix I.

7-6. Collection of Medical Evacuation Information

The medical evacuation information collected for the wartime medical evacuation request, line numbers 3 through 9, is subject to brevity codes. This information is limited to the specific remarks provided in

Table 7-1 (Page 7-7). For example: The information to be collected for Line 4 pertains to special equipment to be placed on board the evacuation vehicle or aircraft. The limiting remarks restrict identification to none required, hoist, extraction equipment, and ventilator. No other remarks are authorized for Line 4.

7-7. Preparation of the Medical Evacuation Request

Table 7-1 provides the procedures for preparation of the medical evacuation request, to include information requirements and sources.

a. During wartime, brevity codes must be used in preparing all medical evacuation requests. The authorized codes are provided in Table 7-1; they are also provided in the SOI. Use of locally devised brevity codes is not authorized. If the unit preparing the request does not have access to secure communications, the medical evacuation request must be prepared in encrypted form. Encrypting is required for all information on the request with the exception of—

(1) The medical evacuation line number identifier. This information is always transmitted in clear text.

(2) The call sign and suffix (Line 2) which can be transmitted in clear text.

b. During peacetime, two line number items (Lines 6 and 9) will change. Details for the collection of information and request preparation are shown in Table 7-1. More detailed procedures for use of the peacetime request format must be developed by each local command to meet specific requirements.

7-8. Transmission of the Request

The medical evacuation request should be made by the most direct communications means to the medical unit that controls evacuation assets. The communications means and channels used depend on the situation (organization, communication means available, location on the battlefield, and distance between units). The primary and alternate channels to be used are specified in the unit evacuation plan.

a. Secure Transmissions. Under all wartime conditions, these requests are transmitted by *SECURE MEANS* only. Therefore, the use of nonsecure communications dictates that the request be transmitted in *ENCRYPTED FORM*. Regardless of the type (secure or nonsecure) of communications equipment used in transmission, it is necessary to—

- Make proper contact with the intended receiver.
- Use the effective call sign and frequency assignments from the SOI.
- Use the proper radio procedure.

- Ensure that transmission time is kept to a minimum (20 to 25 seconds maximum).
- Provide the opening statement: "I HAVE A MEDEVAC REQUEST."

b. Receiver Acknowledgment. After the appropriate opening statement is made, the transmitting operator breaks for acknowledgment. Authentication by the receiving or transmitting unit should be done in accordance with the TSOP.

c. Clear Text and Encrypted Transmissions. If secure communications equipment is used in transmission, the request will be transmitted in *CLEAR TEXT*. However, if the communications equipment used in transmission is not secure, the request must be transmitted in encrypted form with the exception of the following:

(1) The medical evacuation line number identifier (Line 1, Line 2, Line 3, and so forth). This information is always transmitted in clear text.

(2) The call sign and suffix (Line 2) which can be transmitted in clear text.

NOTE

When using DRYAD Numeral Cipher, the same "SET" line is used to encrypt both the grid zone letters and the coordinates (Line 1 of the request). To avoid misunderstanding, a statement should be made that the grid zone letters are included in the message. This must be accomplished unless the TSOP specifies that the DRYAD Numeral Cipher is to be used at all times.

(3) The automated net control device (ANCD) (AN/CYZ-10) is associated equipment for the SINCGARS radios. It is capable of receiving, storing, and transferring data to SINCGARS radios, and from the ANCD to other compatible communications-electronic equipment. The ANCD (AN/CYZ-10) is used primarily for handling COMSEC keys, frequency hopping, and SOI information. (For information concerning the operation of the ANCD [AN/CYZ-10], refer to Technical Manual [TM] 11-5820-890-10-8 .)

d. Letter and Numeral Pronunciation. The letters and numerals that make up the request are pronounced according to standard radio procedures. In transmission of the request, the medical evacuation request line number identifier will be given followed by the applicable evacuation information (example: Line One. TANGO PAPA FOUR SIX FIVE THREE SEVEN NINER).

e. Medical Evacuation Request Line Numbers 1 through 5. The medical evacuation request line numbers 1 through 5 must always be transmitted first. The information enables the evacuation unit to begin the mission and avoids unnecessary delay if the remaining information is not immediately available. The information for Lines 6 through 9 should be transmitted as soon as it is available.

f. Monitoring Requirement. After transmission and acknowledgment are accomplished, the transmitting operator must monitor the frequency (Line 2 of the request) to wait for additional instructions or contact from the evacuation vehicle.

7-9. Relaying Requests

If the unit receiving the request does not control the evacuation means, it must relay the request to the headquarters or unit that has control, or to another relaying unit. When the relaying unit does not have access to secure communications equipment, the request must be transmitted in encrypted form. The method of transmission and specific units involved depends on the situation. Regardless of the method of transmission, the unit relaying the request must ensure that it relays the exact information originally received and that it is transmitted by secure means only. The radio call sign and frequency relayed (Line 2 of the request) should be that of the requesting unit and not that of the relaying unit. If possible, intermediate headquarters or units relaying requests will monitor the frequency specified in Line 2. This is necessary in the event contact is not established by the medical evacuation unit, vehicle, or aircraft with the requesting unit.

Table 7-1. Procedures for Information Collection and Medical Evacuation Request Preparation

LINE	ITEM	EXPLANATION	WHERE/HOW OBTAINED	WHO NORMALLY PROVIDES	REASON
1	Location of Pickup Site	Encrypt the grid coordinates of the pickup site. When using the DRYAD Numeral Cipher, the same "SET" line will be used to encrypt the grid zone letters and the coordinates. To preclude misunderstanding, a statement is made that grid zone letters are included in the message (unless unit SOP specifies its use at all times).	From Map	Unit Leader(s)	Required so evacuation vehicle knows where to pickup patient. Also, so that the unit coordinating the evacuation mission can plan the route for the evacuation vehicle (if the evacuation vehicle must pick up from more than one location).
2	Radio Frequency, Call Sign, and Suffix	Encrypt the frequency of the radio at the pickup site, not a relay frequency. The call sign (and suffix if used) of person to be contacted at the pickup site may be transmitted in the clear.	From SOI	RTO	Required so that evacuation vehicle can contact requesting unit while en route (obtain additional information or change in situation or directions).
3	Number of Patients by Precedence	Report only applicable information and encrypt the brevity codes. A—URGENT B—URGENT-SURG C—PRIORITY D—ROUTINE E—CONVENIENCE If two or more categories must be reported in the same request, insert the word "BREAK" between each category.	From Evaluation of Patient(s)	Medic or Senior Person Present	Required by unit controlling the evacuation vehicles to assist in prioritizing missions.
4	Special Equipment Required	Encrypt the applicable brevity codes. A—None B—Hoist C—Extraction equipment D—Ventilator	From Evaluation of Patient/ Situation	Medic or Senior Person Present	Required so that the equipment can be placed on board the evacuation vehicle prior to the start of the mission.

Table 7-1. Procedures for Information Collection and Medical Evacuation Request Preparation (Continued)

LINE	ITEM	EXPLANATION	WHERE/HOW OBTAINED	WHO NORMALLY PROVIDES	REASON
5	Number of Patients by Type	Report only applicable information and encrypt the brevity code. If requesting MEDEVAC for both types, insert the word "BREAK" between the litter entry and ambulatory entry. L + # of PNT – Litter A + # of PNT – Ambulatory (sitting)	From Evaluation of Patient(s)	Medic or Senior Person Present	Required so that the appropriate number of evacuation vehicles may be dispatched to the pickup site. They should be configured to carry the patients requiring evacuation.
6	Security of Pickup Site (Wartime)	N—No enemy troops in area. P—Possibly enemy troops in area (approach with caution). E—Enemy troops in area (approach with caution). X—Enemy troops in area (armed escort required).	From Evaluation of Situation	Unit Leader	Required to assist the evacuation crew in assessing the situation and determining if assistance is required. More definitive guidance can be furnished the evacuation vehicle while it is en route (specific location of enemy to assist an aircraft in planning its approach).
6	Number and Type of Wound, Injury, or Illness (Peacetime)	Specific information regarding patient wounds by type (gunshot or shrapnel). Report serious bleeding, along with patient blood type, if known.	From Evaluation of Patient	Medic or Senior Person Present	Required to assist evacuation personnel in determining treatment and special equipment needed.
7	Method of Marking Pickup Site	Encrypt the brevity codes. A—Panels B—Pyrotechnic signal C—Smoke signal D—None E—Other	Based on Situation and Availability of Materials	Medic or Senior Person Present	Required to assist the evacuation crew in identifying the specific location of the pick up. Note that the color of the panels or smoke should not be transmitted until the evacuation vehicle contacts the unit (just prior to its arrival). For security, the crew should identify the color and the unit verify it.

Table 7-1. Procedures for Information Collection and Medical Evacuation Request Preparation (Continued)

LINE	ITEM	EXPLANATION	WHERE/HOW OBTAINED	WHO NORMALLY PROVIDES	REASON
8	Patient Nationality and Status	The number of patients in each category need not be transmitted. Encrypt only the applicable brevity codes. A—US military B—US civilian C—Non-US military D—Non-US civilian E—EPW	From Evaluation of Patient	Medic or Senior Person Present	Required to assist in planning for destination facilities and need for guards. Unit requesting support should ensure that there is an English-speaking representative at the pickup site.
9	NBC Contamination (Wartime)	Include this line only when applicable. Encrypt the applicable brevity codes. N—Nuclear B—Biological C—Chemical	From Situation	Medic or Senior Person Present	Required to assist in planning for the mission. (Determine which evacuation vehicle will accomplish the mission and when it will be accomplished.)
9	Terrain Description (Peacetime)	Includes details of terrain features in and around proposed landing site. If possible, describe relationship of site to prominent terrain feature (lake, mountain, tower).	From Area Survey	Personnel at Site	Required to allow evacuation personnel to assess route/avenue of approach into area. Of particular importance if hoist operation is required.

APPENDIX I

SAMPLE FORMAT FOR MEDICAL EVACUATION MISSION COMPLETION RECORD

Once the medical evacuation mission is completed, an after-action record of this mission should be maintained. The information contained in this sample record provides historical data and lessons-learned information. This information can be used as a management tool for ensuring that medical evacuation missions are properly equipped and performed in a timely manner. Further, the record provides information on the patient's condition and procedures accomplished which may have a bearing on either administrative or legal proceedings. The sample format depicted in Table I-1 may be revised to meet the needs of the command and included in the unit TSOP.

Table I-1. Medical Evacuation Request and Mission Completion Record

SAMPLE FORMAT

MEDICAL EVACUATION REQUEST/AFTER-ACTION RECORD

DTG RECEIVED	CALL SIGN	AIR/GROUND	UNIT MISSION/MISSION NUMBER

ITEM	CLEAR/DECRYPTED	ENCRYPTED	BREVITY CODE	ACTUAL INFORMATION
1 LOCATION OF PICKUP SITE				
2 FREQUENCY/ CALL SIGN SUFFIX AT PICKUP SITE				
3 NUMBER OF PATIENTS BY PRECEDENCE			A—URGENT B—URGENT-SURG C—PRIORITY D—ROUTINE E—CONVENIENCE	
4 SPECIAL EQUIPMENT			A—NONE B—HOIST C—EXTRACTION EQUIPMENT D—VENTILATOR	
5 NUMBER OF PATIENTS BY TYPE			L + # OF PNT—LITTER A+ # OF PNT—AMBULATORY (SITTING)	
6 SECURITY OF PICKUP SITE*			N—NO ENEMY TROOPS P—POSSIBLE ENEMY TROOPS (CAUTION) E—ENEMY TROOPS IN AREA (CAUTION) X—ENEMY TROOPS IN AREA (ARMED ESCORT REQUIRED)	
7 METHOD OF MARKING PICKUP SITE			A—PANELS B—PYROTECHNIC SIGNAL C—SMOKE SIGNAL D—NONE E—OTHER	
8 PATIENT NATIONALITY AND STATUS			A—US MILITARY B—US CIVILIAN C—NON-US MILITARY D—NON-US CIVILIAN E—EPW	
9 NBC CONTAMINATION*			N—NUCLEAR B—BIOLOGICAL C—CHEMICAL	

NEAREST AXP	DESTINATION MTF	DEST FREQ/CALL SIGN	ETE

NOTES:
(EXPLAIN DELAYS)
(LIST MSRs OR AIR CORRIDORS)
(LIST EXCHANGE REQUIREMENTS)
*WARTIME

Table I-1. Medical Evacuation Request and Mission Completion Record (Continued)

SAMPLE FORMAT

DTG REQUEST RECEIVED BY EVACUATION UNIT	DTG REQUEST RECEIVED BY EVACUATION CREW	EVAC VEHICLE/AIRCRAFT DESIGNATION (BUMPER NUMBER/AIRCRAFT NUMBER)
DTG ARRIVED AT PICKUP SITE	DTG DEPARTED PICKUP SITE	EVACUATION ORGANIZATION
DTG ARRIVED AT MTF 1	DESIGNATION OF MTF 1	LOCATION OF MTF 1
DTG ARRIVED AT MTF 2	DESIGNATION OF MTF 2	LOCATION OF MTF 2
DTG ARRIVED AT MTF 3	DESIGNATION OF MTF 3	LOCATION OF MTF 3
DTG ARRIVED AT MTF 4	DESIGNATION OF MTF 4	LOCATION OF MTF 4

PATIENT DATA NAME	RANK	SSN/ID NUMBER	UNIT	MTF EVACUATED TO

MISSION NARRATIVE: CHRONOLOGICALLY COVER AS MUCH INFORMATION AS IS AVAILABLE.

EVACUATION CREW: INDIVIDUAL IN CHARGE:	SIGNATURE OF INDIVIDUAL IN CHARGE:
PILOT/DRIVER:	
MEDIC:	
CREW CHIEF:	

CONTINUATION OF INFORMATION: